DMHAS Mental Health Waiver Request Form

Nursing Facility ☐ Community ☐

Name: _____ IMD* ☐: CVH ☐ CMHC ☐ GBMHC ☐

Address _____

City _____ Zip code _____

Phone # _____ Primary Language: _____ Secondary: _____

Date of Birth: _____ ☐Single ☐Married ☐Divorced ☐Widowed

Medicaid ID # _____ Social Security # _____

Medicare ID # _____ Gender: ☐ Male ☐ Female ☐ other:_____

Referral Source Agency: _____ Phone # _____

Name: _____ Title: _____

Relationship: ☐ Self ☐ Family ☐ Agency ☐Other

Conservator of Person: ☐ Yes ☐ No

Name: _____ Telephone # _____

Address _____

City _____ Zip code _____

Currently receiving services from: ☐ Elder Waiver ☐ PCA Waiver ☐ CFC ☐ ABI Waiver

MH Diagnosis Or ICD 10 Code: _____

Current Community Providers:

Clinician _____ Phone _____

Agency: _____

Nursing _____ Phone _____

Agency: _____

Other _____ Phone _____

Agency: _____

ADL needs:

☐ Bathing ☐ Dressing
☐ Feeding ☐ Preparing meals
☐ Transfer ☐ Taking medications
☐ Toileting

Cognitive impairment:

☐ Orientation ☐ Planning
☐ Concentration ☐ Judgment
☐ Attention ☐ Memory
☐ Abstract reasoning ☐ Comprehension

_____ _____

Signature of Applicant or Conservator of Person Date

Request from provider must include psycho social history, functional assessment and current recovery plan.
**IMD referrals MUST include signed Release of Information, signed Informed Consent, and COP decree (if applicable)*

FOR MHW ADMINISTRATIVE USE ONLY			
DDAP ☐ YES ☐ NO	*ASCEND ☐ YES ☐ NO*	*LEVEL II DATE:*	
DATE LOGGED:	*REDETERMINATION DATE:*		
DSS INITIAL STATUS RESULTS: ☐ ELIGIBLE ☐ NEEDS LOOK BACK ☐ NEEDS TO APPLY			
☐ *OTHER:*			
CLINICIAN ASSIGNED:		*DATE ASSIGNED:*	

Fax form and clinical information to (860) 262-5852