SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: FORMS
	Subject: Self-Direct Member Referral SLTC-154

PURPOSE: This form is used as a referral document to request Community First Choice (CFC) and Personal Assistance Services (PAS) from Mountain Pacific Quality Health (MPQH). It also lists important identifying information and, when completed, is part of the Member Functional Assessment, which details pertinent information concerning the member.

PROCEDURE: When a PAS/CFC agency receives a request for services, the agency completes the Referral form and faxes this form to MPQH within one working day.

DISTRIBUTION: The referring agency keeps a copy of the original referral. When the MPQH intake process is completed, the Functional Need Assessment and Service Profile is sent to the member’s agency of choice.

INSTRUCTIONS:

1. Fill in all the available information that you may have. MPQH will complete all other information during the referral intake process.

   - Check the box 4B-CFC if the member is on waiver and wants SD-CFC services. Check the box SD-CFC if the member is on waiver and wants self-directed services. If a member is not on waiver, check either the AB-PAS or SD-PAS box, depending upon whether they want AB or SD.

   - Check whether it is an initial referral, readmit, short-term (less than 3 months) or a change (e.g. change in provider or option).

   - Medicaid ID#--Enter the member's Medicaid number.

   - Name--Enter the member's last name and first name

   - DOB--Enter the member's date of birth.

- Address--Enter member's street, city, and zip code.
- Mailing Address--Enter the member's mailing address, city, and zip code if different than the physical address.
- Telephone--Enter the member's telephone number(s) – home, cell, or message.
- Responsible Party --Enter the name of the person to be contacted concerning services. Enter the contact person's home, cell and work telephone numbers.
- Member--Check this box if the responsible party is the member.
- Legal Guardian--Check this box if the responsible party is the legal guardian.
- Personal Representative--Check this box if the responsible party is the personal representative for the purpose of the self-directed personal assistance program.
- Contact Person--Check this box if the responsible party should be contacted by MPQH to process the referral instead of the member. Agency Based members only.
- Address--Enter the responsible party’s street, city, and zip code.
- Mailing Address--Enter the responsible party’s mailing address, city, and zip code if different than the physical address.
- Change in Option --If applicable, check if this referral constitutes a change in option (AB-CFC to SD-CFC, SD-CFC to AB-CFC, ABPAS to SDPAS, SDPAS to ABPAS, or PAS to CFC).
- New Personal Representative (PR) information – If this referral constitutes a change in the personal representative, enter the new PR’s name, address, phone # and the reason a change is needed.

- Change in Agency-- If this referral constitutes a change in agency, enter the new agency's name, representative and phone number.

- Directions to home and other information--Enter any relevant information pertinent to the member or their situation which would facilitate the completion of the intake/review process by MPQH. Include names and phone numbers of individuals other than the member who need to be present at the home visit.

- Personal Care Needs—check the personal care needs required by the member.

- Comments related to Personal Care Need – Describe the need for PAS/CFC services.

- Health Maintenance Activities—check the health maintenance activities required by the member. Self-Direct referrals only.

- Health Care Professional--Enter the name and the telephone number of the member's primary physician or other health care provider.

- Relevant Medical Diagnosis --List medical diagnoses which contribute to the need for personal assistance.

- Referral Source--Enter the name of the person completing the referral form along with the referring agency's name, phone number, fax number, address, city and zip code.

- FAX--Enter the date the referral form is faxed to MPQH.

2. High Risk Referral:

   a. No--Check "no" if this is not a high risk referral. Do not fill in the remaining blanks in this box.

   b. Yes--Check "yes" if this is a high risk referral. Refer to SD-CFC/PAS 410.

      - Reason--State reason that this is a high risk referral.

- Date services instituted--Enter date services were instituted.
- Biweekly Frequency--Enter the number of days per two-week time period that the agency is providing services under the high risk criteria.
- Total Biweekly Units (Unit = 15 min)--Enter the total units per two-week time period that the agency is providing under the high risk criteria.

3. Provider Agency (or referral entity) FAX form to MPQH.