MISSISSIPPI DIVISION OF MEDICAID

CTS Initial Referral

Fax To: (601) 359-6294 Attn: CTS
or
Mail to: Division of Medicaid Attn: CTS
550 High Street, Suite 1000
Jackson, MS 39201

Applicant Information

Referral Date_____

Name_____ _____ _____ DOB_____
(Last) (First) (MI)

Phone #_____ SSN #_____ Medicaid # _____ Medicare #_____

Does applicant have a legal representative? ☐Yes ☐No Representative's name _____

Phone # _____ Representatives address _____

If yes, what type of legal relationship?☐Guardian ☐Surrogate ☐Conservator☐Power of Attorney ☐Other_____

Is legal representative aware of referral? ☐Yes ☐No

Facility Information

Name of Facility_____ Phone # _____ Fax #_____

Street address_____ City _____ County _____State____ Zip _____

Facility Contact Person_____ Phone #_____

Email address of facility contact person _____

Admit date to facility _____ Reason for admission _____

_____

Diagnoses_____

Is applicant currently taking medication? ☐Yes ☐No

Referral Information **(Areas with * leave blank if Facility Contact and Referral information are the same.)**

*Name of person making referral _____*Relationship to applicant_____

*Street Address_____*City_____*County_____*State____*Zip_____

How did referral source hear about Community Transition Services? _____

Please attach copy of the following documentation:

____Current Medication Record
____Intake (Physician Admission note)
____Behavioral Notes
____Face Sheet (Admission Record)
____POA Documents (If Applicable)
____Social History (History and Assessment)
____ Current MDS (Quick Print if possible)
____30 Days Current Nursing Notes

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Preferred Living Arrangements

Preferred County of Transition _____

Does the applicant need assistance in identifying housing? ☐Yes ☐No If no, where does the applicant intend to live? (If applicant will be living with family/friend please list name, address, contact number, and relationship.)

_____

Has applicant ever tried to transition to community? ☐Yes ☐No

If yes, what circumstances led to reentry into facility? _____

_____

Waiver Information

Does the applicant potentially qualify for the Elderly and Disabled Waiver (E&D Waiver)? ☐Yes ☐No

NOTES