



MISSISSIPPI DIVISION OF
MEDICAID

B2I Initial Referral

Fax To: (601) 359-6294 Attn: B2I

or

Mail to: Division of Medicaid Attn: B2I
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 # _____ Fax # _____

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 Bridge to Independence? _____

Please attach copy of the following documentation:

- ___ Current Medication Record
- ___ Intake (Physician Admission note)
- ___ Behavioral Notes

- ___ POA Documents (If Applicable)
- ___ Social History (History and Assessment)
- ___ Current MDS (Quick Print if possible)



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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

For which Medicaid HCBS program(s) does the applicant potentially qualify? E & D Waiver TBI/SCI waiver

ID/DD waiver IL waiver State Plan Mental Health (Rehab Option)

DOM USE ONLY:

Date beneficiary/guardian contacted by DOM staff _____

Has a PAS Level I been conducted? Yes No Has a Level II been conducted? Yes No

List any previous waiver/CMHC services _____

Initial eligibility requirements met?

90 long term care days in facility One day Medicaid Paid Potentially HCBS eligible Indication of moving to a qualified residence

If no, other options discussed/referrals made _____

B2I provider selected? Yes No If yes, provider name _____

Reviewed by _____

Signature

Date

Signature

Date