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_____ **Date of Birth** _____
(Last) (First) (MI)

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

Does applicant have a legal representative? ☐**Yes** ☐**No**

If yes, what type of legal relationship? ☐**Guardian** ☐**Surrogate** ☐**Conservator** ☐**Power of Attorney** **Other**____

Representative name _____**Phone #**_____

Representative address _____

Is legal representative aware of referral? ☐**Yes** ☐**No**

Facility Information

Name of Facility _____**Phone #**_____**Fax #**_____

Street address_____**City**_____**County**_____**Zip** _____

Facility Contact Person_____**Phone #**_____**Email** _____

Admit date to facility_____**Reason for admission** _____

_____

Diagnoses_____

Please attach a copy of the following documents:

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

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? _____

Notes: