

DMHAS Nursing Home Diversion and Transition Program

REQUEST for DIVERSION NURSE SERVICES

Date of Request: _____

TYPE OF REQUEST

MFP Client (check one below to identify status) Name of current facility: _____

Client Name: _____ DOB ___/___/___

Will transition to community on a HCBS waiver: Anticipated Transition Date _____

Specify Waiver _____

Will transition to the community on State Plan Services: Anticipated Transition Date _____

Address: _____ Telephone: _____

Client's transition status is unclear

Client transitioned to community on State Plan Services on (date) _____.

Other: Require consultation to establish plan _____

Non-MFP Client (resides in community already)

Name of Client _____ DOB _____ Telephone _____

Address of Client: _____

Is client on a Waiver yes no If yes, which one: _____

Is client in crisis requiring Diversion Nurse intervention? yes no

Is client conserved? yes no If yes: COP COE BOTH (please circle)

Community Supports/involved family or friend? yes no If yes, please provide name, contact number, and type of involvement: _____

Reason for Request (What do you want the Diversion Nurse to do?)

Current Providers

Mental Health: _____

Medical Providers: _____

*****PLEASE PRINT ONLY IN NEXT SECTION*****

Person Making Request _____ Relationship _____

From _____

(name of agency; hospital; address)

Telephone _____ Email _____

Fax completed form to Sherry Marconi or Mary Ives at fax number (860) 262-5852.