rev 11.15.18

DMHAS Nursing Home Diversion and Transition Program

REQUEST for DIVERSION NURSE SERVICES

Date of Request: _____ Client Name: _____ DOB ___/___/____

Insurance: ☐ No or list Medicaid (ID#_____) Medicare (ID#_____)

Other Insurance: _____ ID# _____

Conservator: ☐ No ☐ COP ☐ COE ☐ Both COP/COE Name/Number: _____

Current Client Address:_____ Telephone: _____

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TYPE OF REQUEST

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

☐ Expected to transition to a HCBS waiver: Specify Waiver _____

Anticipated Transition Date _____

☐ Expected to transition to State Plan Services: Anticipated Transition Date _____

Address:_____ Telephone: _____

☐ Client's transition status is unclear

☐ Other: Require consultation to establish plan _____

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

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☐ **Non-MFP Client** (resides in community already)

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

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?)

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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 Laurene Gomez or Mary Ives at fax number (860) 262-5852.