**DMHAS Mental Health Waiver Request Form**

Nursing Facility ☐ Community ☐

Name: _____ IMD* ☐: CVH ☐ CMHC ☐ GBMHC ☐

Address _____

City _____ Zip code _____

Phone # _____ Primary Language: _____ Secondary: _____

Date of Birth: _____ ☐Single ☐Married ☐Divorced ☐Widowed

Medicaid ID # _____ Social Security # _____

Medicare ID # _____ Gender: ☐ Male ☐ Female ☐ other:_____

Referral Source Agency: _____ Phone # _____

Name: _____ Title: _____

Relationship: ☐ Self ☐ Family ☐ Agency ☐Other

Conservator of Person: ☐ Yes ☐ No

Name: _____ Telephone # _____

Address _____

City _____ Zip code _____

Currently receiving services from: ☐ Elder Waiver ☐ PCA Waiver ☐ CFC ☐ ABI Waiver

MH Diagnosis Or ICD 10 Code: _____

Current Community Providers:

Clinician _____ Phone _____

*Agency*: _____

Nursing _____ Phone _____

*Agency*: _____

Other _____ Phone _____

*Agency*: _____

ADL needs:

☐ Bathing ☐ Dressing
☐ Feeding ☐ Preparing meals
☐ Transfer ☐ Taking medications
☐ Toileting

Cognitive impairment:

☐ Orientation ☐ Planning
☐ Concentration ☐ Judgment
☐ Attention ☐ Memory
☐ Abstract reasoning ☐ Comprehension

_____ _____

Signature of Applicant or Conservator of Person Date

*Request from provider must include psycho social history, functional assessment and current recovery plan.*
**IMD referrals MUST include signed Release of Information, signed Informed Consent, and COP decree (if applicable)*

| *FOR MHW ADMINISTRATIVE USE ONLY* | | | |
|---|---|---|---|
| *DDAP ☐ YES ☐ NO* | *ASCEND ☐ YES ☐ NO* | *LEVEL II DATE:* | |
| *DATE LOGGED:* | *REDETERMINATION DATE:* | | |
| *DSS INITIAL STATUS RESULTS: ☐ ELIGIBLE ☐ NEEDS LOOK BACK ☐ NEEDS TO APPLY* | | | |
| ☐ *OTHER:* | | | |
| *CLINICIAN ASSIGNED:* | | *DATE ASSIGNED:* | |



Fax form and clinical information to (860) 262-5852