



Request for Services

Date _____

Type of clinical eligibility determination all requested services.

Service(s) requested <input type="checkbox"/> Pre-admission nursing facility (NF) <input type="checkbox"/> Adult day health (ADH) <input type="checkbox"/> Adult foster care (AFC) <input type="checkbox"/> Group adult foster care (GAFC)	<input type="checkbox"/> Home and community based services (HCBS) waiver <input type="checkbox"/> Program for All-inclusive Care for the Elderly (PACE) <input type="checkbox"/> Other _____	Nursing facility use only <input type="checkbox"/> Conversion <input type="checkbox"/> Continued stay <input type="checkbox"/> Short term review <input type="checkbox"/> Transfer NF to NF <input type="checkbox"/> Retrospective
---	--	--

Member information

Member/applicant

Last name	First name	Telephone
Address		City Zip
Check one <input type="checkbox"/> MassHealth member <input type="checkbox"/> MassHealth application pending <input type="checkbox"/> GAFC/ Assisted living residence		
_____	_____	_____
MassHealth ID number	Date application filed	Date SSI-G application filed

Next of kin/Responsible party

Last name	First name	Telephone
Address		City Zip

Physician

Last name	First name	Telephone
Address		City Zip

Screening for mental illness, mental retardation, and developmental disability

Does the member/applicant have any of the following diagnoses/conditions? Check all that apply.

Mental illness Specify: _____

Mental retardation without related condition

Developmental disability with related condition that occurred prior to age 22. **Check all that apply.**

<input type="radio"/> Autism	<input type="radio"/> Deafness/severe hearing impairment	<input type="radio"/> Multiple sclerosis	<input type="radio"/> Severe learning disability
<input type="radio"/> Blindness/severe visual impairment	<input type="radio"/> Epilepsy/seizure disorder	<input type="radio"/> Muscular dystrophy	<input type="radio"/> Spina bifida
<input type="radio"/> Cerebral palsy	<input type="radio"/> Head/brain injury	<input type="radio"/> Orthopedic impairment	<input type="radio"/> Spinal cord injury
<input type="radio"/> Cystic fibrosis	<input type="radio"/> Major mental illness	<input type="radio"/> Speech/language impairment	

Community services recommended

Check all that apply.

- | | | | |
|--|--|---|---|
| <input type="radio"/> Skilled nursing | <input type="radio"/> HCBS waiver | <input type="radio"/> Rest home | <input type="radio"/> Homemaker |
| <input type="radio"/> Physical therapy | <input type="radio"/> Personal emergency response system | <input type="radio"/> Elderly housing | <input type="radio"/> Meals |
| <input type="radio"/> Occupational therapy | <input type="radio"/> Adult foster care | <input type="radio"/> Adult day health | <input type="radio"/> Transportation |
| <input type="radio"/> Speech therapy | <input type="radio"/> Group adult foster care | <input type="radio"/> PACE | <input type="radio"/> Chore service |
| <input type="radio"/> Mental health services | <input type="radio"/> Assisted living | <input type="radio"/> Home health aide | <input type="radio"/> Grocery shopping/delivery |
| <input type="radio"/> Social worker services | <input type="radio"/> Congregate housing | <input type="radio"/> Personal care/homemaker | <input type="radio"/> Other: _____ |

Additional information

1. Is the home or apartment available for the member or applicant? yes no
2. Is there a caregiver to assist the member in the community? yes no
3. Has the member or applicant experienced unexplained weight gain in the last 30 days? yes no
4. Does the member or applicant receive personal care/homemaker services? yes no
 If yes: days per week hours per week
5. Has the member or applicant experienced a significant change in condition in the last 30 days? yes no
 If yes: improvement deterioration
 Indicate the changes below. _____

For nursing facility requests only

1. Does the nursing facility member/applicant express an interest to remain in or return to the community? yes no
2. Is the nursing facility stay expected to be short-term (up to 90 days)? yes no
3. Is the nursing facility stay expected to be long-term (more than 90 days)? yes no

Referral source Name of registered nurse completing this form

Signature	Print name	Title	
Name of organization		Telephone	
Address		City	Zip

For community providers: Attach the MDS-HC and Physician’s Summary form according to provider’s regulations/guidelines.

For nursing facility providers: Attach the most recent comprehensive MDS, current quarterly MDS, and current physician orders.