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**Request for Services**

Date

# Type of clinical eligibility determination all requested services.

**Service(s) requested**

🞏Pre-admission nursing facility (NF)

🞏Adult day health (ADH)

🞏Adult foster care (AFC)

🞏Group adult foster care (GAFC)

🞏Home and community based services (HCBS) waiver

🞏Program for All-inclusive Care for the Elderly (PACE)

🞏Other

**Nursing facility use only**

🞏Conversion
🞏Continued stay
🞏Short term review
🞏Transfer NF to NF
🞏Retrospective

# Member information

**Member/applicant**

Last name

First name

Telephone

Address

City

Zip

Check one

🞏MassHealth member

MassHealth ID number

🞏MassHealth application pending

Date application filed

🞏GAFC/Assisted living residence

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.

🞏Autism

🞏 Blindness/severe visual impairment

🞏 Cerebral palsy

🞏 Cystic fibrosis

🞏 Deafness/severe hearing impairment

🞏 Epilepsy/seizure disorder

🞏 Head/brain injury

🞏 Major mental illness

🞏 Multiple sclerosis

🞏 Muscular dystrophy

🞏 Orthopedic impairment

🞏 Speech/language impairment

🞏 Severe learning disability

🞏 Spina bifida

🞏 Spinal cord injury

Community services recommended

**Check all that apply.**

🞏 Skilled nursing

🞏 Physical therapy

🞏 Occupational therapy

🞏 Speech therapy

🞏 Mental health services

🞏 Social worker services

🞏 HCBS waiver

🞏 Personal emergency response system

🞏 Adult foster care

🞏 Group adult foster care

🞏 Assisted living

🞏 Congregate housing

🞏 Rest home

🞏 Elderly housing

🞏 Adult day health

🞏 PACE

🞏 Home health aid

🞏 Personal care/homemaker

🞏 Homemaker

🞏 Meals

🞏 Transportation

🞏 Chore service

🞏 Grocery shopping/delivery

🞏 Other:

Additional information

1. Is the home or apartment available for the member or applicant?

🞏 yes

🞏no

1. Is there a caregiver to assist the member in the community?

🞏 yes

🞏no

1. Has the member or applicant experienced unexplained weight gain in the last 30 days?

🞏 yes

🞏no

1. Does the member or applicant receive personal care/homemaker services?

🞏 yes

🞏no

If yes:

days per week

hours per week

1. 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

1. Is the nursing facility stay expected to be short-term (up to 90 days)?

🞏 yes
🞏no

1. 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.

RFS-1 (Rev. 10/02)