

## DMHAS Mental Health Waiver Request Form

Name: \_\_\_\_\_ Nursing Facility  Community   
 Address \_\_\_\_\_ IMD\* : CVH  CMHC  GBMHC

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
- Feeding
- Transfer
- Toileting
- Dressing
- Preparing meals
- Taking medications

#### Cognitive impairment:

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

Signature of Applicant or Conservator of Person \_\_\_\_\_ Date \_\_\_\_\_

### FOR MHW ADMINISTRATIVE USE ONLY

DDAP <input type="checkbox"/> YES <input type="checkbox"/> NO	ASCEND <input type="checkbox"/> YES <input type="checkbox"/> NO	LEVEL II DATE:	
DATE LOGGED:	REDETERMINATION DATE:		
DSS INITIAL STATUS RESULTS: <input type="checkbox"/> ELIGIBLE <input type="checkbox"/> NEEDS LOOK BACK <input type="checkbox"/> NEEDS TO APPLY			
<input type="checkbox"/> OTHER:			
CLINICIAN ASSIGNED:		DATE ASSIGNED:	