

CFC/ PERSONAL ASSISTANCE SERVICES MEMBER REFERRAL

AB-CFC SD-CFC ABPAS SDPAS

Initial Readmission Short Term Change

Medicaid ID#	Last Name	First Name	DOB
Street Address	City	Zip	Home Phone Cell Phone
Mailing Address	City	Zip	Message Phone
RESPONSIBLE PARTY			
Name	<input type="checkbox"/> Member <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative (SD only – if other than member) <input type="checkbox"/> Contact Person (AB only - if other than member)		
Street Address	City	Zip	Home Phone Cell Phone
Mailing Address	City	Zip	Work Phone
<input type="checkbox"/> CHANGE IN OPTION (<i>select one</i>): <input type="checkbox"/> AB-CFC to SD-CFC <input type="checkbox"/> SD-CFC to AB-CFC <input type="checkbox"/> ABPAS to SDPAS <input type="checkbox"/> SDPAS to ABPAS <input type="checkbox"/> PAS to CFC (evaluate LOC)			
NEW PERSONAL REPRESENTATIVE (PR) INFORMATION: Name: Address: Phone: Reason for new PR:		CHANGE IN AGENCY New Agency Name: Agency Representative: Phone:	
Directions to home and other pertinent information:			
PERSONAL CARE NEEDS			
<input type="checkbox"/> Bathing	<input type="checkbox"/> Toileting	<input type="checkbox"/> Mobility	<input type="checkbox"/> Exercise
<input type="checkbox"/> Dressing	<input type="checkbox"/> Transfer	<input type="checkbox"/> Meal	<input type="checkbox"/> Medication Reminder
<input type="checkbox"/> Hygiene	<input type="checkbox"/> Position	<input type="checkbox"/> Eating	<input type="checkbox"/> PERS
<input type="checkbox"/> IADLs (Describe):			
COMMENTS RELATED TO PERSONAL CARE NEEDS:			
HEALTH MAINTENANCE ACTIVITIES (Self Direct referrals only)			
<input type="checkbox"/> Urinary Systems Management <input type="checkbox"/> Bowel Care <input type="checkbox"/> Medication Administration <input type="checkbox"/> Wound Care			
HEALTH CARE PROFESSIONAL			
Health Care Professional Name:		Telephone:	
LIST EACH RELEVANT MEDICAL DIAGNOSIS			
REFERRAL SOURCE			
Name	Agency	Phone	Fax
Address	City	Zip	Date
HIGH RISK			
High Risk Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason?			
Date Services Instituted: Number of Days Biweekly (Every Two Weeks) : ____ Number of Units Biweekly (Every Two Weeks): ____ 1 unit = 15 Minutes			