

**CIP II NURSING HOME DIVERSION REQUEST
 COVERSHEET**

Completion of this form is voluntary. Failure to complete this form may result in delayed processing of the request.

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| Recipient: | First Name: | Last Name: | Gender: |
| | MA Number: | DOB: | Care Level: |
| Agency: | Case Manager: | | |
| | Phone: | Fax: | |
| Request: | <input type="checkbox"/> CRI Diversion | | <input type="checkbox"/> Nursing Home Diversion |
| | Waiver Per Diem: \$ | Financial Eligibility Group: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | |
| | Cost Share? \$ | Spousal Impoverishment: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Moving From: | | |
| | <input type="checkbox"/> Home w/Family | <input type="checkbox"/> Home Alone | <input type="checkbox"/> CBRF <input type="checkbox"/> AFH <input type="checkbox"/> RCAC <input type="checkbox"/> Hospital |
| Moving To: | | | |
| <input type="checkbox"/> Home w/Family | <input type="checkbox"/> Home Alone | <input type="checkbox"/> CBRF <input type="checkbox"/> AFH <input type="checkbox"/> RCAC <input type="checkbox"/> Hospital | |
| Official Use: | Date Initial Packet Received: | Date Final Packet Received: | Effective Start Date: |

Notes:

Please submit this completed coversheet to The Management Group (TMG)
 as part of the initial CIP II service plan packet.