

COMMUNITY LONG TERM CARE SERVICES
REFERRAL TO INCOME MAINTENANCE WORKER (IMW)

This is a voluntary form. Failure to complete this form or its equivalent may delay your referral.
 The information contained in this form must be on file in some format.

Name – Applicant (Last, First, MI)		Social Security Number	Medicaid No. if Different
Street Address			Date of Birth
City, State, Zip Code			Telephone Number
Marital Status	Living Arrangement		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Own Home/Apartment	<input type="checkbox"/> Nursing Home—relocating to own home/apt
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Substitute Care Facility	<input type="checkbox"/> Nursing Home—relocating to Substitute Care Facility
		<input type="checkbox"/> Other—specify: _____	

Name – Contact Person	Telephone Number
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Relationship to Applicant (e.g., guardian of person, guardian of finances, POA, Rep. payee, authorized representative, son)

Street Address

City, State, Zip Code

Date of Initial Request for Community Waiver: _____

Is individual a “transfer” to or from a Family Care County? (If yes, **prioritize** for continuous MA): _____

Anticipated Waiver Start Date: _____

Date of Referral from Care Manager/Support & Service Coordinator (SSC)/Resource Center to IM Worker: _____

Name – Care Manager/Support and Service Coordinator	Telephone Number
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Type of Long Term Care Program Target Group Eligibility (check one)	Community Waiver Functional Eligibility?
<input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> CIP II <input type="checkbox"/> COP-W <input type="checkbox"/> Family Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> COR <input type="checkbox"/> PACE <input type="checkbox"/> Partnership <input type="checkbox"/> CLTS <input type="checkbox"/> Brain Injury Waiver	

PACE/Partnership Agencies – Level of Care (LOC) Check One	Family Care - Specify LOC
<input type="checkbox"/> Intermediate Care Facility (ICF) <input type="checkbox"/> Intensive Skilled Nursing (ISN) <input type="checkbox"/> Skilled Nursing Facility (SNF)	

Special Housing Amount in Substitute Care – **Rent only** from Room and Board costs
 \$ _____

Group B¹ - Monthly Out of Pocket Remedial Expenses

Out of pocket expenses only (Do not include health insurance premiums in this figure. IM Worker collects this information separately.)

Group C² - Monthly Medical Remedial Expenses

a. Out of pocket ³	\$ _____	e. Medicaid Card services:	\$ _____
b. COP services (except for COP funded room/board)	\$ _____		
c. Waiver services	\$ _____		
d. Total	\$ _____		

Plan for Processing Application (check one)

Care Manager/SSC will arrange appointment with IMW IMW will arrange own appointment

Other—specify: _____

¹ IMW enters Group B medical/remedial expenses on AFME CARES Screen
² IMW enters Group C medical/remedial and Medicaid card services on ANCW CARES Screen
³ Do not include health insurance premiums in this figure. IM Worker collects this information separately.