NURSING HOME TRANSITION TO COMMUNITY LIVING
MDS 3.0 SECTION Q REFERRAL FORM

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"Yes" to Section Q. Date:

DATE OF REFERRAL

MODE OF REFERRAL

☐ **FAX** ☐ **E-Mail**
☐ **US Mail** (state reason why)_____

I. NURSING HOME

Name of Facility

Street Address | City | State | ZIP Code

Name of Contact | Title

E-mail Address | Telephone Number

II. INDIVIDUAL BEING REFERRED

Name of Individual | Room Number | Date of Birth | SEX Male Female

Telephone Number to reach Individual | County of Preference for Relocation

Yes No Has verbal consent been obtained?
Yes No Does this Individual have a **legal guardian?**
Yes No Does this resident have an **activated Power of Attorney for Health Care (POAHC)?**

Who was consent obtained from? Individual Legal guardian / Representative

Name of Legal Guardian / Activated POAHC | Telephone Number

Current Payer for Nursing Home Stay (*Check all that apply*)
Medicare Medicaid Private Insurance Private Pay

III. Individual's Designated Contact Person (complete if the Individual is competent and requests another individual {e.g., family member, friend} be contacted.

Name of designated contact person | Relationship to resident

Street Mailing Address | City | State | ZIP Code

E-Mail address | Telephone Number

Verbal consent telephonically received by: | Date
Nursing Facility witness to verbal consent:

ADDITIONAL INFORMATION (other referrals made, special considerations, information not reflected on this form)

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The following guidance is provided to you and supported by NH Department of Health and Human Services

1. Completion of this form is required under federal regulation 42 CFR 483.20, which requires federally certified nursing homes to complete the Minimum Data Set (MDS) assessment for all individuals admitted to a skilled nursing center (SNC)/ Intermediate Care Facility (CFI). SNC's and ICFs are required to make a referral to the Local Contact Agency (LCA) for any individual who, in response to the MDS Section Q questions, indicates that he/she wishes to talk with someone about returning to the community.

2. Within three (3) business days of completing Section Q of the MDS, submit a completed copy of this form to the Local Contact Agency (ServiceLink Aging and Disability Resource Center (SLRC), serving the area where the nursing home is located. Please refer to your MDS 3.0 Training Material or the SLRC website servicelink.org for the fax, phone, and e-mail address to your Local Contact Agency.

3. Keep a copy of the referral form in the Individual's medical record.