# REFERRAL FOR LONG-TERM SERVICES AND SUPPORTS OPTION COUNSELING

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING AND DEVELOPMENTAL DISABILITIES (DD) SERVICES DIVISIONS
SFN 892 (3-2022)

Clear Fields

## REFERRAL INFORMATION

| Name | ND Number/Medicaid Number | Date of Referral | | County of Residence |
|---|---|---|---|---|
| Address | City | | State | ZIP Code |
| Telephone Number | Email Address | | | |
| Name of Facility | | Date of Interview | | Follow-up Date |
| Where Did Interview Take Place? ☐ In Person/Face to Face ☐ Virtual/Telephone ☐ Other | | Individual's Location at Time of Interview ☐ Nursing Facility ☐ Hospital ☐ Home/Community | | |

If the interview was conducted virtually/by telephone or if other explain why:

Who was present for the interview?

Is there anyone you would like to be involved in options counseling? ☐ Yes ☐ No
If yes, list the individuals names and contact information:

Does the Individual Have a Guardian or Legal Representative, Family Member, Friend or Other Supportive Person (please check below):
☐ Guardian ☐ Legal Representative ☐ Family Member ☐ Friend or Other Supportive Person

Name of Person: (Guardian or Legal Representative, Family Member, Friend or Other Supportive Person)

| Telephone Number | Email Address |
|---|---|

Describe the reasons you came to the hospital/nursing facility.

☐ The individual does not appear able to complete this form/interview without additional supports.

Indicate the status of the referral (Check the appropriate status)
☐ LTSS-OC Completed ☐ Deceased ☐ Open HCBS ☐ Unable to Locate

☐ Does Not Meet Criteria (check all that apply below):
☐ Hasn't Applied for MA ☐ Short-Term Less Than 90 Days ☐ Out of State Resident

## SERVICES AND SUPPORTS

Were you receiving any in-home services prior to coming to the nursing facility or hospital? (Such as, assistance with housework, shopping, home delivered meals or bathing assistance. Reference assistance that may have been used just prior to nursing home/hospital admission or further back in the past.)
☐ Yes ☐ No

Comments

What challenges have you encountered as you were looking for care options? (For example, before and during your hospital/nursing facility stay)

If these challenges could be addressed, would you like to explore community living again?

How do your supports such as family members, friends, or any legal representatives feel about where you would like to live and receive your cares?

Tell me about your typical daily routine. (Such as, when during your day do you get assistance with your care needs? How would your day be different if you were able to choose your schedule?)

When would you like to get help with these tasks?

☐ During the Day ☐ Overnight ☐ Both ☐ Other

Comments

Describe any medical equipment needed to safely live in the community. For example, shower bars, wheelchair ramp, hospital bed, etc., adaptive equipment such as special spoons, EZ-Shampoo or other supplies.

Do you have any concerns about financially meeting your needs? (such as paying rent, having food and supplies, or managing finances in general)

Were there any other issues that impacted your coming to the hospital/nursing facility?

Describe anything else not discussed that would be important to know about you.

**HOUSING**

Living Situation

☐ My Own Home ☐ Someone Else's Home ☐ No Permanent Residence ☐ Shared Living

Explain More About Your Living Situation

Tell me more about specific challenges you have related to housing?

- ☐ I can't find a place to live in the community where I want to live that meets my needs. (ex., is accessible, is the right size, is somewhere where I can get transportation).
- ☐ I can't find a place to live in the community where I want to live that I can afford.
- ☐ The place I am living now doesn't meet my needs anymore - I need it to be more accessible and I am having trouble getting modifications made. (This answer includes the place the individual was living before coming to the nursing facility/hospital.)
- ☐ The place I am living now doesn't meet my needs anymore - it needs significant repairs and I am having trouble making those repairs.
- ☐ I am struggling to get approved for a new apartment because I don't meet the landlord's background check requirements (credit, criminal, rental history).
- ☐ Other (specify):

Are you interested in visiting community-based settings or having the opportunity to meet with others who are receiving services in the community? (ie. Adult Foster Care (AFC), private housing, apartment or complexes). A community-based setting could be your own house or apartment with supports, or groups of people who live together in the community.

☐ Yes ☐ No-Initial:

If Yes, Enter Notes on Preferences for Housing

**ACTION STEPS**

If the individual is not ready to have a conversation about their care options now, please ask the following:

Would you like me to come back and visit with you again about services in the community?

- ☐ Yes - Enter the follow-up date: _____
- ☐ No - please leave your contact information

Let the individual know that you are assigned to the facility as the LTSS Options Counselor (case manager), which means you will be checking in with them periodically. Also, let them know that they are welcome to reach out to you at anytime.

**REFERRALS**

| Program | Date Referred | Program | Date Referred |
|---|---|---|---|
| ☐ (HCBS) Home and Community Based Services (Aging Services) | | ☐ Public Health | |
| ☐ (DD) Developmental Disabilities Services | | ☐ Supported Decisionmaking | |
| ☐ Peer Support | | ☐ Ombudsman | |
| ☐ (MFP) Money Follows the Person | | ☐ Housing Assistance | |
| ☐ (PACE) Program of All-Inclusive Care for the Elderly | | ☐ (OAA) Older Americans Act | |
| ☐ (CSC) Community Service Coordinator | | ☐ (CIL's) Centers for Independent Living | |
| ☐ Home Health | | ☐ (P&A) Protection and Advocacy | |
| ☐ Other (specify): | | | |

- Note: Please discuss what the referral process looks like and when the individual should expect follow-up from HCBS and MFP.

## ACKNOWLEDGEMENT

**Per ND Administrative Code 75-02-02.4-05. Service availability.**
Eligibility for informed choice services does not create an entitlement to services other than information about home and community-based service options if resources are not available.

By typing my name below, I am signing this application form electronically. I agree that my electronic signature is the legal equivalent of my handwritten signature. I attest that I am the individual completing this application and that I have provided accurate information to the best of my knowledge. NDCC 9-16

| Individual/Guardian or Legal Representative Signature | Date |
|---|---|
| | |

☐ Checking this box indicates that the client has provided verbal consent for signature.

| Department of Human Services Staff Signature | Date |
|---|---|
| | |

Narrative (Information in this section includes the additional information that may be helpful in understanding the individuals situation or needs that may not have been addressed in the previous questions. The narrative section is not "in-leu" of providing information in the previous sections.)