

CFC/ PERSONAL ASSISTANCE SERVICES CONSUMER 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"/> Consumer <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Personal Representative (SD only – if other than consumer) <input type="checkbox"/> Contact Person (AB only - if other than consumer)			
Street Address	City	Zip	Home Phone	Cell Phone
Mailing Address	City	Zip	Work Phone	
<input type="checkbox"/> CHANGE IN OPTION (select one): <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:		CHANGE IN AGENCY		
Name:		New Agency Name:		
Address:		Agency Representative:		
Phone:		Phone:		
Reason for new PR:				
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"/> IADLs (Describe):
<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	
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				

