

ADRC REFERRAL AND DETERMINATION/RE-DETERMINATION

PART I: REFERRAL TO ADRC						☐ SHOTT Application		Completed ADRC Packet Received, Date ____/____/____	
☐ Applicant ____/____/____ Date of Application ☐ Beneficiary									
1. APPLICANT/BENEFICIARY NAME _____ DATE OF BIRTH ____/____/____ Last NameFirst Name									
CASE NO. _____ MQD BENEFICIARY I.D. NO. _____									
2. TYPE OF REFERRAL:									
☐ ADRC INITIAL DETERMINATION									
☐ ADRC REDETERMINATION, DATE LAST ADRC COMPLETED: ____/____/____ (attach a copy of last DHS 1180)									
3. REFERRAL SOURCE:									
☐ DHS: _____ Division/Section / UnitContact PersonPhone No.Fax No.Email									
☐ HEALTH PLAN: _____ Name of Health PlanContact PersonPhone No.Fax No.Email									
4. ATTACHED DOCUMENTS:									
☐ DHS 1127									
☐ DHS 1128 ☐ HCFA 2728 submitted instead of DHS 1128									
☐ DHS 1147, SUB-ACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION, <u>IF APPLICABLE, AND</u>									
☐ ADDITIONAL INFORMATION OR SUPPORTING EVIDENCE FOR PHYSICAL or PSYCHIATRIC DISABILITY FROM THE HEALTH PLAN OR APPLICANT'S/BENEFICIARY'S MEDICAL PROVIDER.									
COMMENTS: _____									
PART II: DETERMINATION BY ADRC:									
1. ☐ UNIT: _____ EW: _____									
☐ HEALTH PLAN: _____ CONTACT: _____									
☐ TREATING PHYSICIAN: _____									
2. GAINFUL ACTIVITY DETERMINATION (based on beneficiary's DHS 1127 statement, system verification of lack of income, other information sources, confirmed by MQD/CSO staff if needed)									
☐ GAINFUL ACTIVITY IS NOT POSSIBLE. ☐ GAINFUL ACTIVITY WAS NOT CONSIDERED									
COMMENTS: _____									
CERTIFIED BY: _____ MQD/CSO Staff____/____/____ Date									
3. ADRC DETERMINATION:									
☐ UNABLE TO DETERMINE									
☐ NOT DISABLED									
☐ PERMANENTLY DISABLED – RE-EVALUATE IN 7 YEARS FROM APPROVAL DATE (____/____/____)									
☐ TEMPORARILY DISABLED UNTIL ____/____/____									
COMMENTS: _____									

CERTIFIED BY: _____ Medical/Psychiatric Consultant____/____/____ Date									