STATE OF HAWAII
Department of Human Services

Med-QUEST Division

MDS Section Q Community Options and/or Going Home Plus Referral Form

(Check one or both)

☐ **MDS SECTION Q** ☐ **GOING HOME PLUS Project**

Instructions for facilities: Please complete the form below for ALL residents who 1) would like to speak to someone about community options (based on MDS Section Q) and/or 2) are potential Going Home Plus participants

Referral Date:	**Medicaid** ☐ No ☐ Yes
Resident Name: (Last, First, MI)	
Medicaid Client ID#: _____ ☐ AlohaCare ☐ HMSA ☐ Kaiser ☐ Ohana ☐ UHC	
☐ **Discharge currently in process**	**Age:**
☐ **Referral to (Agency/Provider name):**	**Date of Birth:**
☐ **Referral to QI Plan (Contact Name):**	**Sex:** ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated	
Facility Name:	
Island: ☐ Oahu ☐ Maui ☐ East Hawaii ☐ West Hawaii ☐ Kauai ☐ Other _____	

Facility Contact:	**Phone Number:**	**Fax Number:**

Name of resident's Authorized Representative (Last, First) ☐ Self
Address of Authorized Representative Mailing Address, City, State and Zip Code:

Primary Diagnosis:	**Weight:**

Nursing Facility Level of Care
DHS1147 Expiration Date:_____ DHS1147 Point Total:_____ ☐ N/A (private pay resident)

Proposed Living Arrangement (if known): ☐ Own Home ☐ Other Family Home ☐ Other Rental
☐ Foster Home (CCFFH-EARCH) ☐ ALF ☐ Other _____

Months institutionalized: _____ **Admit date to institution:** _____

Hx and dates if more than one facility:

1. Admit_____ Transfer_____ Facility_____
2. Admit_____ Transfer_____ Facility_____
3. Admit_____ Transfer_____ Facility_____

FOLLOW UP (To be completed by Local Contact Agency (LCA))

Name/Agency of LCA Representative:
Date LCA Representative Contacted Resident/Family:
Date LCA Representative Met with Resident/Family:
Date Completed Referral Form Returned to the Facility:

****GOING HOME PLUS ELIGIBLITY**: (1)Medicaid; (2) Approved Level of Care on DHS 1147 or DHS 1150; (3)At least 90 continuous days in a hospital, nursing home, ICF-MRc and or rehab facility (not including Medicare short term rehab days):

Madi Silverman **Phone: 808-692-8166 FAX: 808-692-8087 Mail:** P.O. Box 700190 Kapolei, HI 96709-0190

Attach: Facility Face Sheet and Current DHS 1147 form.

FORM PURPOSE

The DHS 1132A, "MDS Section Q Community Options and/or Going Home Plus Referral" form, shall be used by the interested party to request assistance from the Med-QUEST Division regarding community options (based on MDS Section Q) and/or the Going Home Plus Program.

FORM INSTRUCTIONS

1. The referring facility to complete the following:

    a. **Referral Date**: Month-XX/Day-XX/Year-XX
    b. **Medicaid**: Check Yes or No, if the resident being referred has Medicaid.
    c. **Resident Name**: Enter the resident's Last, First and Middle Initial (MI).
    d. **Medicaid Client ID#**: Enter the resident's ID number and select the coverage plan they are under.
    e. **Marital Status**: Select the resident marital status.
    f. **Facility Name**: Enter the Facility Name.
    g. **Island**: Select the Island/Region that the Facility is in.
    h. **Facility Contact**: Enter the Family Contact of the resident Name if applicable.
    i. **Phone Number**: Enter the Family Contact of the resident phone number if applicable.
    j. **Fax Number**: Enter the Family Contact of the resident Fax Number if applicable.
    k. **Name of resident's Authorized Representative**: Enter the Last, First name of the Authorized Representative (if applicable). Select "Self" if there is no authorized representative.
    l. **Address of Authorized Representative**: Enter the Mailing Address, City, State and Zip Code of the Authorized Representative.
    m. **Primary Diagnosis**: Enter the Primary Diagnosis of the resident.
    n. **Weight**: Enter the weight of the resident.
    o. **Nursing Facility Level of Care**: Enter the DHS 1147 Expiration Date and DHS 1147 point total. Select N/A if the resident is a private payer.
    p. **Proposed Living Arrangement** (if known): Select proposed living arrangement. If "Other" is selected, describe on line provided.
    q. **Months institutionalized and admit date to institution**. Enter the months that the resident has been institutionalized at the referring facility. Enter the date that they were admitted. If there is more than one facility that they have been institutionalized at, complete "more than one facility" section as appropriate.

2. **The Local Contact Agency to complete the following:**
    a. Follow-Up-Local Contact Agency (LCA) to enter the Name/Agency of LCA representative, the date the LCA representative contacted the resident/family, the date the LCA representative met with the resident/family and the date the referral form was returned to the facility.

3. Upon completion of this form, The referring facility to send the DHS 1132A, Facility Face Sheet and current DHS 1147 forms to the Going Home Plus Representative:
    Madi Silverman-Going Home Plus-Local Contact Agency
    Phone: 808-692-8166
    FAX: 808-692-8087
    Mail: P.O. Box 700190, Kapolei, HI 96709-0190