Louisiana Department of Health and Hospitals
Office of Aging and Adult Services (OAAS)

DEPARTMENT OF HEALTH AND HOSPITALS

Community Choices Waiver (CCW)
Home Health / Therapy / Nursing / EAA Referral Form
(This page to be completed by the Support Coordination Agency)

Client Name: _____ Last four of SSN: _____

I. Provider Selected by Participant:		II. Support Coordinator (SC) Information:	
Agency/Provider Name: 1111		**SC Agency Name:**	
Address:		**Address:**	
City:		**City:**	
State:	**Zip Code:**	**State:**	**Zip Code:**
Phone #:	**Fax #:**	**Agency Phone #:**	
Date SC Called:		**Referring Support Coordinator (SC):**	
Person who took the call:		**SC Phone #:**	

III. Client Information (See attached page 1 of client's CCW Plan of Care and MDS-HC Assessment)

IV. Type of Provider Referral: (Check all that apply)

- ☐ Home Health ☐ Nursing (Includes Nutritional Consult, as needed)
- ☐ Therapy Services
- ☐ Environmental Accessibility Adaptations Assessment

V. Reason for Referral (check all that apply):

- ☐ Nursing Evaluation
- ☐ Assess Falls/Falls Risk
- ☐ Assess Pain/ Pain Control
- ☐ Assess Decline in Health
- ☐ Assess Medication Compliance
- ☐ Assess Weight (Overweight/Underweight)
- ☐ Assess tube feeding Needs
- ☐ Assess Wound Care Needs
- ☐ Educational/Disease Management Teaching
- ☐ Therapy Evaluation
- ☐ Assistive Devices Evaluation (including DME and Supplies)
- ☐ Environmental Accessibility Adaptations Evaluation (EAA)
- ☐ Other (Refer to narrative below)

VI. Brief Summary Regarding Client's Issue/Problem/Condition:

VII. Support Coordinator's Signature & Title:_____
Print Support Coordinator's Name: _____
Date Referral Sent/Faxed: _____

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Reissued November 1, 2011
OAAS-PF-11-014

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Please return all 3 pages of this form to Support Coordination Agency

This form due back to Support Coordination Agency no later than: _____

Client / Participant Name: _____ Last four of SSN: _____

VIII. Service(s) Currently Provided by You / Your Agency to This Client / Patient (if applicable) (check all that apply)

☐ **Not applicable:** **Provider currently not providing any services to this patient / participant**

Service Type	Payer Source					Frequency
☐ Nursing Services	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ State Plan ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ Aide	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ PT	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ OT	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ ST	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ Hospice	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ State Plan	☐ VA Benefits	☐ Private Pay	☐ Other	
☐ Other:	Medicare ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other	

Provide a brief summary regarding Intensity, duration, and frequency of services checked above:

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IX. Home Health / Therapist / Nursing Recommended Service(s) (check all that apply & include Recommended Payer Source & Estimated # of visits)

Service Type		Payer Source					Estimated # of Visits
☐	Nursing Services	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ State Plan ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	Aide	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	PT	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	OT	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	ST	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ CC Waiver	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	Hospice	**Medicare** ☐ Part A ☐ Part B	**Medicaid** ☐ State Plan	☐ VA Benefits	☐ Private Pay	☐ Other:	
☐	Other:			☐ VA Benefits	☐ Private Pay	☐ Other:	

Therapist / Nurse's /*EAA Findings/Recommendations: Please document your initial assessment findings in the space below (e.g., Nursing Diagnosis; Therapist's evaluations/ recommendations, and plans for the services required by the client/patient, including estimated number of visits recommended payer source, **OR** document your reasons(s) for NOT recommending continued services beyond initial assessment/visit. ☐ **Check here if additional documents attached** (e.g., additional info./evaluation summary reports, etc.) *Attach EAA Evaluation Report.

Attestation: Medicaid is to be the payer of last resort. Where a private insurance or other third payer exists, any and all other monies must be utilized before Medicaid provides any assistance. Federal Regulation 42 CFR 433.139 requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits. Third parties include but are not limited to, private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare. As an enrolled CCW Medicaid provider, I understand that I may be subject to federal recoupment from failure to bill liable third party first.

Home Health/Therapist/Nursing/EAA Representative's Signature & Title: _____

Print Representative's Name: _____

Date Referral Returned / Faxed: _____

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