SKILLED CARE REFERRAL FOR LONG-TERM SERVICES AND SUPPORTS (LTSS)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 584 (9-2021)

Clear Fields

SKILLED FACILITY/REFERRAL'S INFORMATION

Facility Name	Facility Telephone Number	Referral Date	
Discharge Planner Name	Email Address		
Address	City	State	ZIP Code

Type of Referral

☐ Family ☐ Section Q Request ☐ Consumer
☐ Friend ☐ Information Only ☐ Physician
☐ LTCF ☐ Wants to go Home ☐ Other (specify):

Referral(s) Telephone Numbers

RESIDENT INFORMATION

Name of Individual (First, MI, Last)	Admission Date	Date of Interview	
Address	City	State	ZIP Code
Telephone Number	Gender ☐ Male ☐ Female	Date of Birth	

Hospice Services ☐ Yes ☐ No

Impairment ☐ Hearing ☐ Vision ☐ Communication ☐ Cognitive

Payment Source (choose all that apply)

☐ ND Medicaid ☐ Medicare ☐ Friend ☐ Private Pay ☐ Long-Term Care Insurance

Full Medicaid Number (if ND Medicaid)

If the Payment Source is Medicare/Private Pay, Medicare only, or Private Pay only, complete the following three questions:

1. Is the individual looking for resources? ☐ Yes ☐ No Is the individual looking to go home? ☐ Yes ☐ No
2. Is the individual's household assets over $50,000.00? (include Checking, Savings, Money Markets, CDs, Bonds, Annuities, IRAs, Residence other than primary)
   ☐ Yes ☐ No-Specify Amount if under $50,000: _____
3. Is the individual's household income above $2,000.00 per month? (include Social Security, Pension, Employment, VA benefits)
   ☐ Yes ☐ No-Specify Amount: _____

Marital Status ☐ Single ☐ Married ☐ Divorced/Separated ☐ Significant Other ☐ Widow

Is resident a Veteran? ☐ Yes ☐ No

Prior Living Arrangements

Does the Applicant have a Guardian/Legal Representative? ☐ Yes ☐ No

Type of Guardianship/Legal Representative ☐ Full ☐ Limited ☐ Conservatorship

Guardian's/Legal Representative Name (first and last name)		Telephone Number	
Address	City	State	ZIP Code

Does the Applicant have a Durable Power of Attorney (D-POA)? ☐ Yes ☐ No

Type of D-POA ☐ Health ☐ Financial ☐ Both

Durable Power of Attorney Name (first and last name)		Telephone Number	
Address	City	State	ZIP Code

Reason for Coming to the Skilled Facility

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

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). ☐ Yes ☐ No

If yes, why?

I can't find a place to live in the community where I want to live that I can afford. ☐ Yes ☐ No

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. ☐ Yes ☐ No

The place I am living now doesn't meet my needs anymore - it needs significant repairs and I am having trouble making those repairs. ☐ Yes ☐ No

I am struggling to get approved for a new apartment because I don't meet the landlord's background check requirements (credit, crimina, rental history). ☐ Yes ☐ No

Other

Primary Medical Diagnoses/Mental Health

Is the individual currently receiving any therapy services? ☐ Yes ☐ No

Specify Tasks You Need Help With
☐ Mobility - moving from room to room in your home, or from place to place in your neighborhood
☐ Eating - planning and preparing meals, and eating safely without help
☐ Going to the bathroom
☐ Taking a bath or shower
☐ Other (specify):

Describe what would help you do these tasks as independently as possible:

Describe your living situation and where you would like to move to (such as town/community):

When would you like help with these tasks?
☐ During the Day ☐ Overnight ☐ both ☐ Other

Have you used any services in the past, such as help with housework or personal cares?
☐ Yes ☐ No

Do you have family, friends, or people you have used (paid or unpaid) in the past who are willing and able to help you with these needs?
☐ Yes ☐ No

Is that who you would want to provide the care?
☐ Yes ☐ No

Describe any medical equipment needed to safely live in the community. For example: shower bars, wheelchair ramp, hospital bed, etc.)
Describe anything else not discussed that would be important to know about you:
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 older people who live together in the community. ☐ Yes ☐ No-Initial: _____
If Yes, Enter Notes on Preferences for Housing

FAMILY/CAREGIVER INFORMATION

Primary Caregiver Name (first and last name)	Telephone Number	Relationship to Individual Being Referred	
Address	City	State	ZIP Code

Who would the individual like present at the meeting?

Name	Telephone Number	Name	Telephone Number

STOP - Coordinator will fill out meeting information:

Date of Interview	How did the meeting occur? ☐ In-Person ☐ Video Conference ☐ Telephone ☐ Other
Summary of Visit/Transition Goal	
Would you like to explore the option of remaining in your home or community if services were there to help you? ☐ Yes ☐ No	
Date Referred	
Program Referrals ☐ HCBS Services ☐ Public Health ☐ Peer Support ☐ Ombudsman ☐ ADRL Transition Services ☐ MFP ☐ Housing Assistance ☐ PACE ☐ OAA Programs ☐ Other ☐ CSC ☐ CIL's ☐ Home Health ☐ Community Transition Under Waiver	
If the meeting did not take place, explain why?	

MONEY FOLLOWS THE PERSON (MFP) ONLY CHECKLIST

Has a copy of the Care Plan and Medication (MAR) List been obtained? ☐ Yes ☐ No
Has a MFP Information Consent Document been signed? ☐ Yes ☐ No

SIGNATURES

Resident, Legal Guardian, or D-POA's Signature	Date

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

Name of Individual (CSC/HCBS/MFP) Completing the Referral	Title	Date

The completed SFN 584 can be submitted the following ways to Aging Service Division:

- Clicking the button below to submit online;
- Emailing the completed document to carechoice@nd.gov; or
- Faxing to Aging Services at 701.328.8744

Email Completed Form

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