Missouri Long-Term Care Ombudsman Program

Show-Me Home Referral Form

FAX TO: SHOMARI ROZIER 573.522.4888	
FROM (PLEASE PRINT OR TYPE):	FAX:
PHONE:	DATE:
REFERRAL (COMPLETED BY REGIONAL LTCOP COORDINATOR)	
FACILITY NAME & ADDRESS:	FACILITY TELEPHONE:
RESIDENT'S NAME:	RESIDENT'S DATE OF BIRTH:
RESIDENT'S CONDITION: (ATTACH ANOTHER SHEET IF NEEDED)	RESIDENT'S SSN:
	RESIDENT'S DCN:
	DATE ENTERED SNF:

DISPOSITION (NOTIFY SMH OVERSIGHT STAFF WITHIN **30** DAYS)

☐ RESIDENT APPROVED FOR SMH — DATE OF ENROLLMENT:

☐ RESIDENT DOES **NOT** MEET ELIGIBILITY REQUIREMENTS - CHECK ALL THAT APPLY.

- ☐ NOT MEDICAID ELIGIBLE
- ☐ NO QUALIFIED HOUSING AVAILABLE
- ☐ GUARDIAN REFUSED PARTICIPATION
- ☐ RESIDENT NOT IN SKILLED NURSING FACILITY (SNF) FOR 90 DAYS
- ☐ RESIDENT QUALIFIED BUT NOT APPROVED DUE TO HEALTH AND SAFETY CONCERNS
- ☐ RESIDENT IN SNF SOLELY FOR THE PURPOSE OF SHORT-TERM REHABILITATION FUNDED BY MEDICARE

☐ RESIDENT DOES NOT MEET LEVEL OF CARE FOR HOME AND COMMUNITY BASED SERVICES

SMH/RC NAME: PHONE:

COMMENTS (COMMUNITY SUPPORTS, CHALLENGES, ETC.)

CHECK BOX IF ADDITIONAL PAGES ATTACHED ☐

(04/22)