

## Kentucky Transitions Pre-Transition Referral

<b>Eligibility:</b>	Medicaid recipient at least one day: <input type="checkbox"/> Y <input type="checkbox"/> N (Verified: _____ )		
	Institutionalized at least 90 consecutive days: <input type="checkbox"/> Y <input type="checkbox"/> N (Verified: _____ )		
<b>Date:</b>	<b>Received by:</b>		
<b>Applicant Name:</b>			
<b>Current Facility:</b>			
	(Name)		(Phone)
(Address)	(City)	(County)	(Zip)
<b>Admit Date:</b>			
Does the member have a legal and/or state guardian? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, the list the legal and/or state guardian name and phone number below.			
<b>Legal Guardian/POA</b>			
	(Name)		(Phone)
Does the member have a family contact? <input type="checkbox"/> Y <input type="checkbox"/> N; If yes, list the family contact name and phone number below.			
<b>Family Contact:</b>			
	(Name)		(Phone)
<b>Referral Source:</b>			
How did you hear about Kentucky Transitions?			

<b>DOB:</b>	<b>Anticipated Transition Date:</b>		
<b>Medicaid ID#:</b>			<b>SS#:</b>
<b>Previous Home Address:</b>			<b>Phone:</b>
<b>Preferred transition location:</b>			
Does the member have a home to return to? <input type="checkbox"/> Y <input type="checkbox"/> N			
IF yes, member would like to return to: <input type="checkbox"/> Own Home <input type="checkbox"/> Family members' home;			
Will a modification to the home be required? <input type="checkbox"/> Y <input type="checkbox"/> N			
If the member does not have a home to return to, please explain:			

<b>Other:</b>	
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