Kentucky Transitions Referral

KENTUCKY TRANSITIONS
275 E. Main Street, 6W-B
Frankfort, KY 40601
Fax 502-564-8029
kentucky.transitions@ky.gov

Date: _____ **Received by:** _____
KY Transition Staff

Individual's name/Phone number:_____

Current Facility: _____

Phone: _____

Nursing Facility Address: _____

City, State, County, Zip: _____

Facility Social Worker & Email_____

Admit Date_____ **Last Day Medicare was used**_____

Natural Supports or Legally Responsible Individual (LRI)/POA/Family/Family Contact:

_____ **Phone:** _____
Name Relationship

Referral Source_____ **Section Q Y____ N ____**

Medicaid ID #_____ **SS #**_____

Primary Diagnosis (with ICD 10 code):

_____

Axis 2 Diagnosis: _____

Other Pertinent Information:

_____

If the referral is incomplete, the facility social worker will be contacted to submit a complete form. A referral will not be processed until it is complete.

Please read to the individual/LRI and have individual/LRI sign.

Information above was recently submitted on your behalf to Kentucky Transitions because you are interested in returning to the community with the assistance of Kentucky Transitions. Submitting a referral to Kentucky Transitions starts a prescreening process to review if an individual may be eligible for the Kentucky Transitions Program. Only those individuals who meet the prescreening criteria will go on to a formal application. The facility social worker will inform you if you do not meet the requirements to advance to a full review. If you do not agree with the result of the prescreening, you may contact the Kentucky Transitions office (502) 564-0330.

Signed: _____ **Date:** _____
Individual / Legally Responsible Individual

Referral Form Instructions

Date: Please input the date that the referral is sent to Kentucky Transitions (KYT) office.

Received By: This is to be filled out by the KYT staff.

Individual's Name: Please input the individual's name as it appears on their KY Medicaid card and provide a cell number if the individual has one.

Current Facility: Please input the name of the facility that the individual resides in, the main phone number, the address, city, **county**, and zip.

Facility Social Worker: Please input the name, email address, and phone number of the facility social worker that will need to be contacted to complete the individual's prescreening, and who will be the point of contact throughout the transition process.

Admit Date: Please input the date the individual was admitted into the facility under long term care. To be eligible to participate in the MFP Program, an individual must reside in LTC institutional facility for a minimum of 60 consecutive days.

Last day of Medicare: If Medicare is paying for rehab services, please provide the last date for which services were billed.

Legally Responsible Individual (LRI)/POA/Family Contact: Please circle the appropriate relationship of the contact and input their name and phone number.

Referral Source: Please input who initiated the referral for the individual.

Section Q: Please select whether this referral was initiated due to the individual answering yes to the question Q question on the MDS.

Medicaid #: Please input the individual's active Medicaid ID number.

Social Security #: Please input the individual's social security number.

Primary Diagnosis: Please input the individual's primary diagnosis with ICD 10 code. Please do not attach the face sheet, or any other documents to indicate the diagnosis.

Axis 2 Diagnosis: Please input any mental illness diagnosis. You do not have to include the ICD 10 codes.

Other pertinent information: Please input any other information that is important for KYT staff to know prior to complete assessment.

Signed: & Date: Please have the individual/LRI sign and date the form, ensuring that they understand if they do not meet the basic requirements, as determined by the prescreening, that their referral will not be processed for transitioning.

All areas of the form must be completed.

If an incomplete referral is received, we will attempt to contact you to complete the referral but cannot process the referral until it is complete.