MDS 3.0 Section Q Referral Form

Client's name: _____ Date of birth: _____

Today's date: _____ Facility admission date: _____

Facility name: _____

Do you want to learn more about the possibility of returning to the community? ☐ Yes ☐ No

If yes, the Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services (The Bureau) will send you a packet of information about the various programs and options that may be available to help.

To whom would you like the packet to be sent?

*Name: _____

Relationship: ☐ Self ☐ Family ☐ Facility Staff ☐ Other _____

Complete mailing address: _____
(Street address)

_____
(City) (State) (Zip)

Are you a Utah Medicaid recipient? ☐ Yes ☐ No

Within 10 days, The Bureau will send the packet of information to the person* listed above. If the packet has not been received by the end of 10 days, please forward another request.

Please send this form to The Bureau either by mail or by fax:

Bureau of Authorization and Community Based Services
Division of Medicaid and Health Financing
Department of Health
P.O. Box 143112
Salt Lake City, Utah 84114-3112

Fax: 801-323-1586