DMHAS Mental Health Waiver Request Form

*Request from provider **MUST** include psycho social history, functional assessment or current recovery plan.*
**IMD referrals MUST include signed Release of Information, signed Informed Consent, and COP decree (if applicable)*
Fax form and clinical information to (860) 262-5852

Nursing Facility ☐ Community ☐
Name: _____ IMD* ☐: CVH ☐ CMHC ☐ GBMHC ☐
Address _____
City _____ Zip code _____
Phone # _____ Primary Language: _____ Secondary: _____
Date of Birth: _____ ☐Single ☐Married ☐Divorced ☐Widowed
Medicaid ID # _____ Social Security # _____
Medicare ID # _____ Gender: ☐ Male ☐ Female ☐ other:_____
Referral Source Agency: _____ Phone # _____
Name: _____ Title: _____
Relationship:
☐ Self ☐ Family ☐ Agency _____ ☐Other _____

Conservator of Person: ☐ Yes ☐ No
Name: _____ Telephone # _____
Address _____
City _____ Zip code _____

Currently receiving services from: ☐ Elder Waiver ☐ PCA Waiver ☐ CFC ☐ ABI Waiver
MH Diagnosis Or ICD 10 Code: _____

Current Community Providers:

Clinician _____ Phone _____
Agency: _____
Nursing _____ Phone _____
Agency: _____
Other _____ Phone _____
Agency: _____

ADL needs:
☐ Bathing ☐ Dressing
☐ Feeding ☐ Preparing meals
☐ Transfer ☐ Taking medications
☐ Toileting

Cognitive impairment:
☐ Orientation ☐ Planning
☐ Concentration ☐ Judgment
☐ Attention ☐ Memory
☐ Abstract reasoning ☐ Comprehension

_____ _____
Signature of Applicant or Conservator of Person Date

FOR MHW ADMINISTRATIVE USE ONLY			
DDAP ☐ *YES* ☐ *NO*	*ASCEND* ☐ *YES* ☐ *NO*	*DATE LOGGED:*	
CLINICIAN ASSIGNED:		*DATE ASSIGNED:*	

Rev. 4/9/21