SHOW-ME HOME
A Money Follows the Person Program

ATTACHMENT C
REFERRAL NOTIFICATION

Participant's Name: _____

DCN or DOB: _____ Nursing Facility Admission Date: _____

Check those that apply below:

☐ Options Counseling Services were not provided

☐ Options Counseling Services have been provided but LOC assessment is not indicated

☐ Participant is not interested in transition services

If additional space is needed for explanation (beyond information in the SMH system):

_____

_____

_____

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_____

_____

Options Counselor: _____ Date: _____

SEND TO THE DSDS SMH REGIONAL COORDINATOR