Janet T. Mills
Governor

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Commissioner

Maine Department of Health and Human Services
MaineCare Services
Case Mix/Classification Review
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NURSING HOME MDS 3.0 SECTION Q REFERRAL

1. Federal regulation 42 CFR 483.20 requires federally certified nursing facilities to complete the Minimum Data Set (MDS) assessment for all residents, regardless of payment source. In addition, nursing facilities are required to make a referral to the local contact agency (LCA) for any resident who, in response to MDS Section Q item Q0600, indicates he/she wishes to talk with someone about returning to the community. **In Maine, the local contact agency is the Long-Term Care Ombudsman Program.**

2. **Fax** the completed form within two (2) business days of completing Section Q of the MDS to the Long-Term Care Ombudsman Program at **207-621-0509**.

3. Keep a copy of the referral form in the resident's medical record.

Date of Referral	

I. Nursing Home Information

Name of Nursing Home			
Address	City	State ME	Zip Code
Name – Staff Person	Title		
Email address	Telephone number		

II. Resident Being Referred

Name of Resident	Date of Birth	Gender ☐ Male ☐ Female
Date of admission to NF	County of Preference for Relocation	Telephone Number to Reach Resident

Does this resident have a **legal guardian** ☐Yes ☐No

Does this resident have an activated Power of Attorney for Health Care (POAHC) ☐ Yes ☐ No

Did resident give consent for referral to the Ombudsman Program? ☐ Yes ☐ No

Name of Legal Guardian or Activated POAHC	Telephone Number

Current Payer for Nursing Home stay *(check all that apply)*

☐ MaineCare ☐Private Insurance ☐ Department of Veteran Affairs

☐ Medicare ☐Private Pay ☐ Other

III. Resident's Designated Contact Person

Complete this section if the resident is competent and requests that another individual (e.g. family member, friend, etc.) be contacted.

Name of Designated Contact Person	Relationship to Resident		
Mailing Address	City	State ME	Zip Code
Email Address	Telephone Number		

IV. Resident's Signature *(optional)*

Signature: ☐ Resident ☐ Legal Guardian ☐ Activated POAHC	Date Signed