DMHAS Mental Health Waiver Request Form

*Request from provider **MUST** include psychosocial history, functional assessment, or current recovery plan.*

Form and clinical information can be faxed to (860) 262-5852 or emailed to MHW-DMHAS@ct.gov

Nursing Facility ☐ Community ☐ GBMHC ☐

Name: ______________________ IMD* ☐: CVH ☐ CMHC ☐ Res.Care Home ☐

Address ______________________

City ______________________ Zip code ______________________

Phone # __________ Primary Language: __________ Secondary: __________

Date of Birth: __________ ☐Single ☐Married ☐Divorced ☐Widowed

Medicaid ID # __________ Social Security # __________

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ other:__________________

Mental Health Diagnosis (DSM V or ICD 10 code): ____

Psychosocial history attached ☐ Functional Assessment attached ☐ Current plan of care attached ☐

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

Current Community Providers:

Clinician __________ Phone __________

Agency: ______________________

Nursing __________ Phone __________

Agency: ______________________

ADL needs: (check all that apply)

☐ 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:*	

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**IMD referrals MUST include signed Release of Information, signed Informed Consent, and COP decree (if applicable)*

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