Mission Care at Bennington
Referral Form

Mission Care at Bennington is a privately owned licensed nursing facility in Bennington, Vermont that cares for individuals who meet nursing home level of care criteria and who are difficult to place because of a mental health or behavioral condition and/or known involvement in the criminal justice system. Before submitting a referral, please review the following pre-screen questions to assure each applies by initialing the box to the left of each question:

☐ 1. A nursing facility is the most appropriate, least restrictive setting for the individual being evaluated for placement.

☐ 2. The individual and their representative(s) support the placement.

☐ 3. A payment source has been identified.

☐ 4. Other Vermont nursing facilities will not consider the individual for admission due to complex care needs and/or history of justice involvement.

☐ 5. A Pre-admission Screening Resident Review (PASRR) has been completed or is in process.

Referral Information

1. Individual Name: _____ 2. Date of Birth: _____
3. Address: _____
4. Current Location: _____
5. Primary Contact Name: _____
6. Phone Number: _____
7. Address: _____
8. Relationship to individual: _____

9. Legal Representation: (check all that apply)

☐ Guardian/ Name: _____ Phone: _____
☐ Power of Attorney/ Name: _____ Phone: _____
☐ Health Care Agent/ Name: _____ Phone: _____

10. Primary Physician Name: _____
11. Phone Number: _____
12. Address: _____

13. Other important people (family and/or professionals) who will be involved in the admission and care planning process.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

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14. Payment Source: (Check all that apply)
- ☐ Medicare
- ☐ Vermont Medicaid
- ☐ Private Insurance
- ☐ Private Pay

15. If Vermont Medicaid is the payment source, indicate the status of Choices for Care eligibilty:
- ☐ Currently eligible for Choices for Care.
- ☐ Pending eligibilty, application submitted _____ (date)
- ☐ Application has not been submitted. Indicate in comments who is helping with the application and when the application will be submitted.

Payment Source Comments:

Clinical Summary

1. Medical Diagnosis:
2. Mental Health Diagnosis:
3. Medication Assisted Treatment: ☐ No ☐ Yes: _____
4. Clinical Summary:

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Justice Involvement

1. Does this individual have a known history in the criminal justice system? ☐ No ☐ Yes
2. If yes, please describe:

3. Will this individual require supervision from the Department of Corrections? ☐ No ☐ Yes
4. Will this individual be required to register with the VT Sex Offender registry? ☐ No ☐ Yes

Referral Submission

Please submit this referral form along with the following information to AHS.DAILiCareReferrals@vermont.gov (DAIL inbox).

- ☑ **REQUIRED**: Statement describing the reasons why this is the least restrictive in-state option available and why other Vermont nursing facilities will not serve this individual.
- ☑ **If applicable and available**: Copy of legal representation (guardianship/power of attorney/ advanced directives).
- ☑ **If available**: Copy of PASRR review.
- ☑ **REQUIRED**: Recent clinical information with documentation of care needs

Click here for Choices for Care applications

Person Making the Referral

Name: _____ Phone: _____
Email: _____
Agency Name: _____
Address: _____

I agree everything in this referral form is true to the best of my knowledge.

_____ _____
Signature Date