MissionCare at Bennington
Referral Form

MissionCare at Bennington is a privately owned skilled nursing facility 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 prescreen questions to assure each applies by initialing the box to the left of each question: *All fields MUST be filled out or the referral will be sent back for completion.

☐ 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 Preadmission 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: Medicare number: _____
    - ☐ Vermont Medicaid: Number: _____
    - ☐ Private Insurance: Name and ID number: _____
    - ☐ 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 (include barriers to other nursing homes not offering admission) :
   _____
   _____

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

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Referral Submission

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

- ☑ **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).
- ☑ **REQUIRED**: Copy of PASRR review.

NOTE: DAIL staff will confirm receipt of the referral and perform an initital screening within two business days. An assessment and in-person visit by MissionCare at Bennington staff will occur prior to making admission decisions. The timeline for admission is dependent upon the completeness of all required information submitted during the referral and assessment process, and confirmation of a secure payment source.

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