

LONG TERM CARE ADMINISTRATION REFERRAL FORM

Please Select a Program

Medically Fragile Waiver Program

Personal Information

Last Name	First Name	M.I.	Phone #
SoonerCare ID or SSN	Date of Birth	Age	Sex
Do you have a Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, Who? Name:		Phone #
Do you have a Medical Decision Making Power Of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, Who? Name:		Phone #
Family Contact (Name):	Relationship:	Phone #	

Current Services

Currently Receiving any other Medicaid or Medicare Services: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Services:
Program Name:	Medicaid Services:

Person Making Referral:

Self
 Family Member
 Nursing Facility
 Other

Name:	Agency/Relationship:	Phone #:
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How did you hear about the Medically Fragile Waiver Program?
 Self Family Member ADvantage DHS Other:

List Additional Services Needed (Not currently provided)

FOR OFFICIAL USE ONLY

Date Received:	Received By:
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