Acentra HEALTH

Options Counseling Referral Request Form

The following referral form is to be completed by the Nursing Facility after the referral has been made. Upon completion of this form, please fax to 833-521-2627 or email to NCLIFTSSLCA@acentra.com

Beneficiary Demographics

Date of Referral: _____

Beneficiary's Name: First: _____ Last: _____

DOB: ___ /___/_____ **Phone Number**: (____) _____

Date of Admission: ___ /___ /____

Payor Source: _____

Is there a Guardian or Power of Attorney? ☐ **Yes** ☐ **No (If yes, please provide contact info below)**

Alternate Contact Information: ☐ **Significant Other** ☐ **Guardian** ☐ **Power of Attorney**

Name: _____ **Phone Number:** (____) _____

Referring Facilities Contact Information

Name of Staff Contact: _____

Phone Number: (____) _____

Email Address: _____

Name of Facility: _____

Facility Address: _____ **City:** _____

County: _____ **Zip Code:** _____

Pre-Visit Questions

1. **Will the individual require any accommodation for the face-to-face meeting?** ☐ **Yes** ☐ **No**
   a. **If yes, what is the accommodation needed?** _____
2. **Does the individual have the capacity to comprehend and retain the information that would likely be shared?** ☐ **Yes** ☐ **No**
3. **Does the individual have the capacity to communicate the information discussed during the interview with others?** ☐ **Yes** ☐ **No**
4. **Where does the person want to move?** _____
5. **When is the best date and time to visit?** _____
6. **Additional information:** _____

_____