

## NURSING HOME

### MDS 3.0 SECTION Q REFERRAL AND NON-MDS Q REFERRAL

#### INSTRUCTIONS

1. This form is to be completed by the Skilled Nursing Facility (SNF) staff in which the resident resides.
2. Completion of this form is required under federal regulation 42 CFR 483.20, which requires federally certified nursing homes to complete the Minimum Data Set (MDS) assessment for all residents. Nursing homes are required to make a referral to the local contact agency (LCA) for any resident who, in response to the MDS Section Q question number Q0500 B., indicates that the resident wishes to talk with someone about returning to the community. The referral should be made to the LCA and categorized as a MDS Q referral. Failure to comply with this requirement could result in regulatory enforcement action.
3. In the State of Wisconsin, the Department of Health Services (DHS) designates the Aging and Disability Resource Centers (ADRCs) as the LCA.
4. A **non-MDS Q** is when a resident requests to talk with someone about returning to the community or expresses a desire to move from the facility separate from the MDS Section Q assessment. A referral should be made to the ADRC and categorized on the referral form as a **non-MDS Q referral**.
5. MDS Q and non-MDS Q referrals may only need to be made once during the course of a year unless there has been a change in condition or circumstance.
6. Send the completed form within ten (10) business days of completing Section Q of the MDS assessment to the ADRC. To locate an ADRC click here: [Find an ADRC](#).
7. If the resident is enrolled in a long-term care program, send the referral to the care manager, nurse, or independent consultant agency working with the resident. In addition, remind the resident to reach out to their long-term care program contact to discuss their return to the community. Contact information for a Managed Care Organization (MCO) providing Family Care can be found here: [Family Care MCOs Key Contacts](#) and contact information for an Independent Consultant Agency providing Include, Respect, I Self-Direct (IRIS) can be found here: [IRIS Consultant Agencies](#).
8. Once the form is completed, the SNF staff must send the referral via fax or email to the ADRC in the resident's county of residence. The county of residence/responsibility is not necessarily the county in which the facility is located. County of residence is the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation. The four criteria in the definition of residency includes physical presence, intent to remain, living in a place of fixed habitation, and must be voluntary for an individual to establish residency. All four criteria must occur simultaneously. If the person has a protective placement order, the county in which the court order was established is the county of residence. If the county of residence/responsibility is unknown, the facility should email [dhsdqacguardianship@dhs.wisconsin.gov](mailto:dhsdqacguardianship@dhs.wisconsin.gov) to assist in a residency determination before contacting the appropriate ADRC. To locate an ADRC click here: [Find an ADRC](#).
9. Please include the following if applicable, the resident's face sheet, current diagnoses, activated power of attorney documentation, guardianship court orders, protective placement court orders, and other documents specific to this referral.
10. It is important that the resident is aware that a referral has been made to the ADRC and that someone from this agency will be in contact with them to discuss their request to return to the community.
11. For additional training information for completing form F-00311 go to the [RAI/MDS 3.0 Website](#) section Q referral process section.

**REFERRAL INFORMATION****Date of Referral**

Click or tap to enter a date.

MDS Q

Non-MDS Q

**I. Nursing Home Information**

Name - Facility

Address – Street

City

State

Zip Code

Name – Staff Person Completing this Form

Title

Email Address

Phone Number

**II. Resident Information**

Resident Name

Room Number

Date of Birth/Age

Gender

Choose an item.

Residents Permanent Street Address

City

State

Zip Code

Proposed Date of Discharge, if known

Click or tap to enter a date.

Resident Cell Phone Number

Resident Room Phone Number

Date of Admission

Click or tap to enter a date.

Is this a short-term admission?

 Yes  No

Ethnicity Race

Choose an item.

Preferred Language

In what county was the resident living in prior to SNF admission?

At the time of admission, the resident Choose an item.Does this resident have a **protective placement**?  Yes  No If yes, which County?Does this resident have a **legal guardian**?  Yes  NoDoes this resident have an **activated Power of Attorney for Health Care (POAHC)**?  Yes  No

County of residence/responsibility?

Did the legal decision maker or designated contact participate in the MDS Q assessment?  Yes  No

Name – Legal Guardian/Activated POAHC

Phone Number

Current Payer for Nursing Home

Stay (Check all that apply)

Medicaid

Medicare

Private Pay

Family Care/Partnership/PACE

Department of Veterans Affairs

Other (please list)

**III. Resident's Designated Contact Person (complete if resident would like another individual to be contacted)**

Name – Designated Contact Person

Relationship to Resident

Mailing Address - Street

City

State

Zip Code

Email Address

Phone Number

**IV. Additional Information (Optional)**