



NURSING FACILITY MDS 3.0 SECTION Q REFERRAL

1. Federal regulation 42 CFR 483.20 requires federally certified nursing facilities to complete the Minimum Data Set (MDS) assessment for all residents, regardless of payment source. In addition, nursing facilities are required to make a referral to the local contact agency (LCA) for any resident who, in response to MDS Section Q item Q0600, indicates he/she wishes to talk with someone about returning to the community. **In Maine, the local contact agency is the Long Term Care Ombudsman Program.**
2. **Fax** the completed form within two (2) business days of completing Section Q of the MDS to the Long Term Care Ombudsman Program at **207-621-0509**.
3. Keep a copy of the referral form in the resident's medical record.

Date of Referral			
I. Nursing Home Information			
Name of Facility			
Address		City	State ME
			Zip Code
Name – Staff Person		Title	
Email address		Telephone number	
II. Resident Being Referred			
Name of Resident		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of admission to NF	County of Preference for Relocation	Telephone Number to Reach Resident	
Does this resident have a legal guardian <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does this resident have an activated Power of Attorney for Health Care (POAHC) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Did resident give consent for referral to Ombudsman Program? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Legal Guardian or Activated POAHC		Telephone Number	
Current Payer for Nursing Home Stay (<i>check all that apply</i>)			
<input type="checkbox"/> MaineCare <input type="checkbox"/> Private Insurance <input type="checkbox"/> Department of Veteran Affairs <input type="checkbox"/> Medicare <input type="checkbox"/> Private Pay <input type="checkbox"/> Other			
III. Resident's Designated Contact Person			
<i>Complete this section if the resident is competent and requests that another individual (e.g. family member, friend, etc.) be contacted.</i>			
Name of Designated Contact Person		Relationship to Resident	
Mailing Address		City	State ME
			Zip Code
Email Address		Telephone Number	
IV. Resident's Signature (optional)			
Signature: <input type="checkbox"/> Resident <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Activated POAHC			Date Signed
_____			_____