



## PathWays Medicaid Waiver Health and Wellness Medicaid Waiver Assisted Living Reserved Capacity Referral Form

Waiver (select one): ☐ Health & Wellness ☐ PathWays

Does the Individual have an MCE? ☐ YES ☐ NO

If YES, which MCE? ☐ Anthem ☐ Humana ☐ United Healthcare

### Assisted Living Facility Detail:

Name of Assisted Living Facility:

Assisted Living Facility Contact Name:

Direct Phone Number:

Email:

### Individual Demographic Detail

Name:

Date of Birth:

Assisted Living Facility Move In date:

Medicaid Eligibility Date:

RID (Medicaid Identification Number):

Medicaid Benefit Aid Category (Aged, Blind, or Disabled):

Medicaid Eligible for LTSS: ☐ YES ☐ NO

### Submitter:

Name of Submitter:

Email of Submitter:

Submitter's Relationship to Individual: ☐ Individual ☐ Assisted Living Facility ☐ MCE ☐ AAA

If AAA, indicate which one:

### ATTESTATION:

☐ I attest the individual has granted permission for this to be submitted on their behalf.

Email Referral Form and signed lease to [medicaid@fssa.in.gov](mailto:medicaid@fssa.in.gov).

\*Enter in Subject Line: FSSA Assisted Living Reserved Capacity Referral