

Bobby Jindal
GOVERNOR



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State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

MEMORANDUM

OAAS-P-14-003

TO: Louisiana Nursing Facilities
Louisiana Nursing Home Association
Leading Age Gulf States

FROM: Anne Olivier 
Division Director, Program Operations

DATE: August 21, 2014

SUBJECT: Procedural Change for Section Q Referrals

Please note there is a procedural change for MDS 3.0 Section Q referrals. Effective August 21, 2014, facilities will be required to send the attached form (Form No. OAAS-PF-13-016) via Right Fax (secured fax) to the OAAS Regional Office in the facility's area. A fillable PDF version of the form can be found on the OAAS website at www.dhh.la.gov/oaas under the **Resources** tab, **Provider Resources** link:
<http://new.dhh.louisiana.gov/index.cfm/newsroom/category/73>.

Right Fax numbers for the Regional Offices can be found at:
<http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/SectionQ/Reg-Office-Right-Fax.pdf>

A list of the Offices is attached for your convenience.

Please contact OAAS Regional Office in your area if you have any questions.

AO: jk

Enclosures

Office of Aging and Adult Services (OAAS)

OAAS REGION 1

1450 Poydras Street, Suite 1133
New Orleans, Louisiana 70112
Phone #: 504-568-8568; Fax #: 504-599-0293
Right Fax #: 866-873-8599

OAAS REGION 2

628 N. 4th Street, 2nd Floor
Baton Rouge, Louisiana 70821
Phone #: 225-219-1917; Fax #: 225-219-1904
Right Fax #: 866-887-0968

OAAS REGION 3

1222 Tiger Drive
Thibodaux, Louisiana 70301
Phone #: 985-449-4708; Fax #: 985-449-4706
Right Fax #: 866-887-1719

OAAS REGION 4

825 Kaliste Saloom Road, Brandywine Bldg. II, Suite 102
Lafayette, Louisiana 70508
Phone #: 337-262-1635; Fax #: 337-262-1300
Right Fax #: 866-887-1814

OAAS REGION 5

One Lakeshore Drive, Suite 700
Lake Charles, Louisiana 70629
Phone #: 337-491-2199; Fax #: 337-491-2005
Right Fax #: 866-887-2296

OAAS REGION 6

3600 Jackson St. Suite 122
Alexandria, Louisiana 71303
Phone #: 318-767-6053; Fax #: 318-487-5968
Right Fax #: 866-887-4641

OAAS REGION 7

3018 Old Minden Road, Suite 1109
Bossier City, Louisiana 71112
Phone #: 318-741-2700; Fax #: 318-741-2722
Right Fax #: 866-887-4749

OAAS REGION 8

24 Accent Drive, Suite 103
Monroe, Louisiana 71201
Phone #: 318-362-5070; Fax #: 318-362-4611
Right Fax #: 866-887-7035

OAAS REGION 9

71128 Highway 59, Suite 101
Abita Springs, Louisiana 70420
Phone #: 985-871-8389; Fax #: 985-871-8304
Right Fax #: 866-888-2492

**NURSING FACILITY
MDS 3.0 SECTION Q REFERRAL**

1. Completion of this form is required under federal regulation 42 CFR 483.20, which requires federally certified nursing facilities to complete the Minimum Data Set (MDS) assessment for all residents. Nursing facilities are required to make a referral to the local contact agency for any resident who, in response to the MDS Section Q questions, indicates that he/she wishes to talk to someone about returning to the community. When a resident indicates that he or she does not want to talk to someone about the possibility of returning to the community or if the result of the Section Q questions is that a referral is not needed, then this referral is not necessary.

2. Keep a copy of the referral form in the resident's medical record.

Date of Referral

I. Resident Being Referred

Resident Name: _____ Resident DOB: _____ Resident SSN: _____

Resident Gender: M F Resident Phone Number: _____ Is resident a Veteran? Yes No

Does resident have family contact? Yes No

If yes, who? _____ Family Contact Phone Number: _____

Is the resident any of the following..?

Interdicted*? Yes No

Court ordered to be in a NF? Yes No

*If interdicted, indicate name of curator: _____

Curator Phone Number: _____

Is resident a registered sex offender? Yes No

Does resident have a criminal history? Yes No Unknown

II. Nursing Facility

Nursing Facility Name: _____

Nursing Facility Parish: _____ Nursing Facility Region: _____

Staff Person Name: _____ Staff Person Title: _____

Staff Person Email: _____ Staff Person Ph. Number: _____

Date of admission: _____ # of days since admission: _____

III. Additional Resident Information

Does resident have a mental illness noted on the Level 1 PASSR or Resident Review? Yes No

If yes, please list diagnoses, medications, and any specialized services: _____

Does resident have a Level II on file? Yes No

Sources of income with income amount:

1) Source: _____

Income Amount: \$ _____

2) Source: _____

Income Amount: \$ _____

3) Source: _____

Income Amount: \$ _____

Is housing needed to transition? Yes No

If yes, has the Nursing Facility explored resident's options and where? Yes No

What areas/places would resident be willing to live? _____

What actions have you taken to locate housing? (i.e., added name to waiting list, etc.) _____

Housing Comments: _____

NOTE: Please attach the portion of the resident's POC related to discharge.

PLEASE EMAIL COMPLETED FORM TO THE OFFICE OF AGING AND ADULT SERVICES

For a list of local contact agencies, see:

<http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/SectionQ/Reg-Office-Right-Fax.pdf>