Local Contact Agency
Facility Communication Form

TO: _______________________________
_______________________________
_______________________________

FROM: _______________________________
_______________________________
_______________________________

DATE: _______________________________

Reference

Referral # ________________________________ Visit
Date: ________________________________

The individual subject to the referral noted above received a visit from an Options Counselor of the MDS 3.0 Section Q Local Contact Agency.
☐ The OC was unable to complete the interview because ____________________________
☐ The OC was unable to complete the interview. Referral for follow-up will be made to ____________________________
☐ The individual subject to the referral made no requests.
☐ At the individual’s request, the following information is shared ____________________________

☐ Individual requests Money Follows the Person Application be completed and submitted.

________________________________
Options Counselor Name
________________________________
Phone Number

This document was developed by the N.C. Department of Health and Human Services under grant CFDA 93.779 from the Centers for Medicare and Medicaid Services. However, the content does not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government.

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