Questionnaire: Referral Refusal

Referral Refusal Information

1. *Agency Contact Name*

2. *Agency Contact Phone Number (digits only)*

3. *Agency Contact Email Address*

4. *Please indicate the date member was referred to service*

5. *Please indicate the reason why you are seeking authorization to decline referral*
(Please select between 1 and 5 items.)
   - ☐ Agency at staffing capacity
   - ☐ Patient Refused
   - ☐ Guardian Refused
   - ☐ Member recommended for higher level of care
   - ☐ Cannot accept due to medical needs

If you answered "Agency at staffing capacity" on question 5

5.2.1. *Please explain the reason your agency is at staffing capacity (i.e. short staffed, fully staffed but all staff are at capacity etc.)*

5.2.2. *Do you have other clients on your waitlist?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 5.2.2

5.2.2.1.1. *How many clients on your waitlist?*
Min/Max - 0/99999999; No decimal places allowed

5.2.3. *When do you anticipate you will be able to open this client? Please provide approximate date*

If you answered "Member recommended for higher level of care" on question 5

5.5.1. *Please explain why the client is recommended for a higher level of care and which service they are recommended for*

6. *Would you be able to accept this referral with accommodations?*
(Please select one.)
   - ○ Yes
   - ○ No

If you answered "Yes" on question 6

6.1.1. *Please indicate the accommodations needed*