Referral Form

Client’s Full Name :\_\_Frances Macon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB and Age: \_83\_\_\_\_\_\_\_\_\_\_\_\_

* *If* ***under 65****, do they have Medicare? Please circle Yes or No*

Client’s Full Address: \_250 Euclid Ave. Apt J

Client’s Phone Number: \_(619) 318-8467

Language Client Speaks: \_English\_\_\_\_\_\_\_\_\_\_

Responsible Party name/number (friend, family, etc) : Self\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Type:

* ~~Medicare~~
* Medical
* Other

Income Type & monthly amount $: \_\_$2400\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What resources can we connect the client to? Write information about the client that would be relevant for the intake. (special needs/accommodations, health concerns, has a voucher, undergoing eviction, can’t climb stairs, etc). :

#### home/community care recipients, hospice care referrals, in home assistance registries, errand running/shopping assistance, in home hair and nail care, in home meal preparation, personal care, specialized information and referral, adults with disabilities/health conditions, home/community care recipients, adults with disabilities/health conditions

patient with very limited income had to move to current apartment as there was nothing else she can afford. patient has income of 2400 a month. rent is 1200 a month. has no family support. please assist looking for either assisted living or a senior apartment. May need caregiving services as well