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| --- |
| **REFERRAL SOURCE INFORMATION** |
| Name of Referring Person:Name of Referring Agency:Phone: | Referral Date:Email: |
| **CONSUMER INFORMATION** |
| Name: Address:City/Zip:Phone:Gender: ☐F ☐M ☐TDOB: SSN:Marital Status: W M S D  | Does the consumer know that a referral is being made on their behalf? Y NDoes the consumer live alone? Y NIf no, who do they live with?  |
| **ALTERNATE CONTACT** |
| Is there anyone who should be contacted prior to (or instead of) the consumer being contacted? Y NAlternate Contact Name:Alternate Contact Phone:Relationship to Consumer:Consumer Primary Language: If not English, is an interpreter needed? Y N Interpreter Name & Relationship:Phone: |
| **INSURANCE and INCOME INFORMATION** |
| Medicare #:MassHealth #:Other Insurance Name/#:Estimated Monthly or Annual Income: $ |
| **PCP/HEALTH PROVIDER INFORMATION** |  |
| Provider Name:Phone: | Hospital Affiliation:Fax: |
| **EMERGENCY CONTACT** |  |
| Name:Address:City/Zip:Relationship to Consumer: | Email:Phone: Cell Phone:Circle One: HCP Guardian |
| **HOSPITAL OR NURSING FACILITY DISCHARGE** |  |
| Was the Consumer discharged from a hospital, nursing facility, or other institution in the past 90 days? Y NHospital name:Discharge Date:Reason for Admission:Nursing Facility name:Discharge Date:Reason for Admission: | Was Consumer discharged with Certified Home Health Care? Y NProvider Name:List certified services: |
| **DIAGNOSES and REASON FOR REFERRAL** *(briefly describe the situation)* |
|  |
| **CHECK All SERVICES REQUESTED**  |
| * **HOME CARE**
* **OPTIONS COUNSELING**
* **FAMILY CAREGIVER SUPPORT PROGRAM**
* **PCA PROGRAM**
* **GROUP ADULT FOSTER CARE (GAFC)**
* **ADULT FOSTER CARE (AFC)**
* **SHINE Counselor**
* **Aging & Disability Resource Consortia (ADRC)**
* **Chronic Disease Self-Management classes (Pain, Diabetes, Heart Disease, etc.), Falls Prevention (Matter of Balance or Tai Chi), Other Healthy Aging (Healthy Eating, Tools for Caregivers, Depression Management).**

 \_\_Grocery shopping \_\_Personal care (bathing, dressing, toileting, etc.) \_\_Homemaking \_\_Laundry \_\_Personal Emergency Response System \_\_Heavy Chore \_\_Transportation \_\_Companion Care \_\_Escort to appointments ­­\_\_Respite* **HOME DELIVERED MEALS/CONGREGATE MEALS**
* **MASSHEALTH SCREENING**

\_\_Adult Day Health (ADH)\_\_Long Term Care (nursing facility)\_\_Short Term Care (nursing facility)\_\_Frail Elder Waiver |

**Consumer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**