|  |  |  |
| --- | --- | --- |
| **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 ☐T  DOB:  SSN:  Marital Status: W M S D | Does the consumer know that a referral is being made on their behalf? Y N  Does the consumer live alone? Y N  If 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 N  Alternate 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 N  Hospital name:  Discharge Date:  Reason for Admission:  Nursing Facility name:  Discharge Date:  Reason for Admission: | Was Consumer discharged with Certified Home Health Care? Y N  Provider 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**