Area Agency on Aging, Inc.
SPECIALISTS IN AGING

Referral Worksheet

Thank you for choosing Region IV Area Agency on Aging.
To better assist in processing your referral please fill out the information below as complete as you are able.
Please Fax Clearly Printed Form to (269) 983-1057

Has the Client/Family been informed of the referral? **Yes ☐ No ☐**

CLIENT / PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms.	First Name:	Last Name:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Address:	City:	Zip:	County:

DOB:	Age:	Sex: ☐ M ☐ F	SSN:	PH: ( )

Living Arrangements: ☐ Alone ☐ Spouse ☐ NH ☐ Family ☐ Other:

REFERRAL INFORMATION

**** DO YOU HAVE PERMISSION FROM CLIENT TO SPEAK ON THEIR BEHALF? ☐ Yes ☐ No**

Referral Source Name:	PH: ( )
Primary Doctor:	PH: ( )

Current Hospital / NH:	Last Admit Date:	Discharge Date:

Diagnosis / Needs:

Current Services in Place:
Funding Source for Current Services in Place:

NEEDS: (Check all that apply)

☐ Hands on Assist, transferring, feeding	☐ Hx – Depression	☐ Social Isolation
☐ Therapy	☐ Confusion, dementia, memory problems	☐ End of Life care
☐ Hospice	☐ Dialysis	☐ Oxygen
DHS Home help chore provider help? ☐ Y ☐ N	☐ Senior Services	☐ Meals on Wheels

FAMILY / CAREGIVER / SOCIAL SUPPORTS

Sch. Appt. w/? ☐ Yes ☐ No	Relationship:	Home Phone: ( )
Name:	Address:	Cell Phone: ( )
Sch. Appt. w/? ☐ Yes ☐ No	Relationship:	Home Phone: ( )
Name:	Address:	Cell Phone: ( )

FINANCIAL / INSURANCE INFORMATION

Income Sources: Social Security Disability, LTC Insurance payments, etc.)	SSDI: $	SSI: $

Social Security: $	Spouse SS: $	Pension: $	Spouse: : $	Other: : $

Assets: All liquid able assets including: CD's, IRA's, Stocks, Bonds, Trusts, Cash value of life insurance, Money Markets, additional property and vehicles (1 home and 1 vehicle are exempt)	Total Value: $

Checking: $	Savings: $	Life Insurance: $		

Medicaid: ☐ Yes ☐ No Medicaid #: Case Worker: Phone: ( )	NOTES: