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|  | HOME AND COMMUNITY SERVICES (HCS)**Adult Day Service Referral** | 1. REFERRAL TO: |
| 2. REFERRED FROM:[ ]  HCS [ ]  AAA | 3. DATE OF REFERRAL |
| All fields are required unless “optional” is indicated in the field. | 4. PROVIDER AUTHORIZATION NUMBER |
| 5. CLIENT’S NAME (LAST, FIRST, MIDDLE INITITAL) | 6. DATE OF BIRTH | 7. PHONE NUMBER (AND AREA CODE)**(     )** |
| 8. ACES ID NUMBER | 9. CLIENT’S ADDRESS: STREET CITY STATE ZIP CODE |
| 10. PRIMARY CAREGIVER’S NAME OR AGENCY NAME | 11. PHONE NUMBER OF AGENCY**(     )** |
| 12. REFERRED PROGRAM [ ]  Adult Day Care [ ]  Adult Day Health [ ]  To be determined at the center |
| 13. REASON FOR REFERRAL[ ]  Unstable / potentially unstable diagnosisClient has one or more of the following diagnoses (check all that apply):[ ]  Diabetes [ ]  CHF [ ]  COPD [ ]  Recurrent UTI’s [ ]  Edema [ ]  Dementia [ ]  Obesity [ ]  Stroke [ ]  ALS [ ]  Parkinson’s [ ]  TBI [ ]  MS [ ]  Other:  [ ]  Medication regimen affecting plan of care[ ]  Mobility issues affect plan of care Client has one or more of the following conditions (check all that apply): [ ]  Poor balance [ ]  Poor transfers [ ]  Fall history [ ]  Deconditioning  [ ]  Unsteady gait [ ]  Poor hand / eye coordination [ ]  Limited ROM [ ]  Uses wheelchair [ ]  Uses walker [ ]  Uses cane[ ]  Current or potential skin problem[ ]  Nutritional status affecting plan of care[ ]  Other:  |
| 14. REQUESTED ACTIVITY (CHECK ALL THAT APPLY)[ ]  Nursing Assessment [ ]  OT Assessment [ ]  PT Assessment [ ]  Speech Assessment[ ]  Audiology Assessment [ ]  Social Work consult [ ]  Rehab Assessment [ ]  Other:  |
| 15. ADDITIONAL INFORMATION |
| 16. REFERRING CASE MANAGER’S NAME | TITLE |
|  PHONE NUMBER (AND AREA CODE) **(     )** | FAX NUMBER (AND AREA CODE)**(     )** | EMAIL ADDRESS |
| **IMPORTANT: Please be sure to fax or email current CARE Assessment with referral** |
| **Confirmation of Acceptance** |
| [ ]  Referral received; date received: [ ]  Referral accepted[ ]  Referral not accepted; reason(s):  |

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| **Adult Day Service Referral Instructions****All fields are required unless “optional” is indicated in the field.**1. Referral To: Enter the adult day centers name.
2. Referred From: Identify what office the referral is being sent from.
3. Date of Referral: Enter date referral was sent to adult day center.
4. Provider Authorization Number: Enter approved adult day center authorization number.
5. Client’s Name: Enter client’s full name (last, first, and MI).
6. Date of Birth: Enter client’s date of birth (month, day, and year).
7. Telephone Number: Enter client’s telephone number, include area code.
8. ACES ID: Enter clients ACES ID.
9. Client’s Address: Enter client’s physical address (house address, city, state, zip code).
10. Primary Caregiver’s Name or Agency Name: Enter the name or agency name of client’s primary caregiver.
11. Telephone number of Agency: If an agency is the client’s primary caregiver, list the agency phone number, include area code.
12. Referral Program: Identify which program the client’s is being referred to. If unable to determine, check “to be determined at the center.”
13. Reason for Referral: Identify why the client is being referred to adult day services. If reason is not identified on the referral form, indicate why under “other”.
14. Requested Activity: Identify what activity the client is being referred for. If reason is not identified on the referral form, indicate what activity under “other”.
15. Additional Information: Enter additional information which is pertinent to the clients care or useful for the adult day center to know.
16. Referring Case Manager’s Name / Title, Phone, Fax number, and Email address: Enter the name and title of the referring case manager with contact information (telephone, fax, and email address).

Confirmation of Acceptance: The adult day center will respond to the referral within two business days, acknowledging receipt of referral as illustrated by a date and response.  |