CarePoint Home Health

Phone: (651)998-2400 Fax: (866)359-1633
Email: referral@carepointhomehealth.com

REFERRAL DATE: _____

PCA & Waiver Services Referral Form

Referring Party Information

Name of Referrer: _____ Title: _____

Organization: _____ Client Relation: _____

Phone: _____ Extension: _____ Email: _____

Service Request Information

P C A Services

Assessed Hours per Week _____	Traditional ☐ Choice ☐ Extended ☐ Shared ☐
SCHEDULE REQUESTED: _____ AM to _____ AM	*Please circle or click the days preferred, if known.* Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐

HCBS Waiver Services *Please note the hours assessed after the chosen service.*

☐ 24-Hour Emergency Assistance _____	☐ Personal Support _____	☐ Semi-independent Living Skills _____
☐ Adult Companion _____	☐ Respite Care (In- & out-of-home)_____	☐ Supported Living Services-Adult _____
☐ Homemaking _____	☐ In-Home Family Support _____	☐ Behavioral Support _____
☐ Ind. Community Living Support _____	☐ Independent Living Skills _____	☐ Specialist Services _____
☐ Night Supervision _____	☐ Individualized Home Supports _____	

SCHEDULE REQUESTED: _____ AM to _____ PM	*Please circle or click the days preferred, if known.* Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐

Schedule Notes:

Client Information

RECIPIENT'S Contact Information

_____
First **Last** **MI**

_____
Address

_____
City **State** **Zip**

_____ _____
Mobile **Home Phone**

_____
Email Address

SS# _____-_____-_____ **SEX:** _____ **DOB:** _____/_____/_____

- **The client lives:** Alone ☐ w/Parent ☐ w/Spouse ☐
  If Other, please describe_____
- **Does the client have any pets?** Yes ☐ No ☐
  **If yes, note type & size _____
- **Does the client smoke cigarettes in the home?** Yes ☐ No ☐
- **Does the client's home have internet accessibility?** Yes ☐ No ☐
- **Does the client have a caregiver gender preference?**
  Male ☐ Female ☐ No preference ☐

RESPONSIBLE PARTY (RP)Contact Information

_____
First **Last**

_____
Address

_____
City **State** **Zip**

_____
Mobile

_____
Email:

_____
Relationship to Recipient

NAME of Emergency Contact, if no RP

_____
First Last

_____
Mobile

_____
Email

_____
Relationship to client

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REFERRAL DATE: _____

Client Medical Status

PRIMARY DIAGNOSIS: _____

SECONDARY DIAGNOSIS: _____

1. Does the client have any allergies? Yes ☐ No ☐

Type: _____

2. Code Status:

Full ☐ DNR ☐ DNI ☐ DNR/DNI ☐ Modified DNR ☐

3. Any hospitalizations in the last 14 days? Yes ☐ No ☐

If YES, please note the reason below.

Does the client have/require the following? *Check all that apply.*

☐ **Behaviors**
Type: _____

☐ **Catheter**
Type: _____

☐ **Vent**
Type: _____

☐ **Feeding Tube**
Type: _____

☐ **Uses Assistive Ambulation Devices**
Type: _____

☐ **Trach**

☐ **Home IV**

☐ **Oxygen**

Billing Information

Medical Assistance Subscriber ID#:	**If over AGE 65, list the name of MCO/Insurance Provider:**
List ALL waiver types received, if any:	**If applicable, indicate the Spend Down dollar amount to be collected by this provider: $**

Additional Information

Please provide any additional information that may be helpful in pairing this client with one of our CarePoint Caregivers.

Please email the completed referral form to referral@carepointhomehealth.com or fax to 651.998.2400. Thank you very much!

Office Use Only		
Date received		By:
Date reviewed		By:
Accepted		By: