CARING HANDS HOMECARE

Referral Form: NPI/ 1952026759

Select Service Type

☐IHS Without Training	☐Respite In/out Home	☐Respite Crises
☐Night Supervision	☐IHS In-Home Family Support	☐Adult Companion
☐Homemaking	☐Private Duty Nursing	☐Skilled Nursing

Today's Date: / /

INDIVIDUAL'S INFORMATION

Full Name:	DOB (mm/dd/yyyy): / /	Sex: ☐ Male ☐ Female

Address:	City:	State:	Zip:

Phone #:	MA #:	County:

Waiver Type/Payment Source: ☐ DD ☐ CADI ☐ CAC ☐ AC ☐ Private Pay ☐ Other (list):

Are Medical Assistance and the waiver currently active? ☐ Yes ☐ No What is the renewal date:

Number of hours per week of services being requested:

Rate:

Availability:
Please fill out the days of the week, and available times for this person to work with staff. This information is necessary so that we can have staffing available.

Day	Sun	Mon	Tue	Wed	Thru	Fri	Sat
Time							

When would you like to start services? / / Talk to client to determine start date

Guardianship Status: ☐ Self ☐ Other (list name & contact info):

CASE MANAGER INFORMATION

Premium Health Services values the presence, support and input of case managers on the support team. We ask that case managers coordinate and attend the intake meeting of the person being referred. Ensuring the best coordination possible for people taking the step towards full community integration is our goal.

Case Manager Name:	Phone #:
County/Agency:	Fax #:

Address:	City:	State:	Zip:

Email:

Please fill out this form with as much detail as possible and return it with a copy of the most current Coordinated Service and Support Plan.

Email referral to caring.hands546@gmail.com or fax to 651-413-2862