Dynamic Services CLIENT REFERRAL

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| Name of HQ employee taking referral: Referral source: Date: | | | | | |
| Case Manager Name: | | | | | |
| Case Manager Email: | | | Case Manager Phone Number: | | |
| Client Name: | | Client Phone Number:  Video Phone:  Cell: | | | |
| Date of Birth: | Gender:  Male Female | | | | Guardianship Status:  Self Private Public  Guardian Contact:  Jean: |
| Funding Source:  Waiver  MA  ARMHS  Shelter Needy  GRH Other:  Private Pay  LTC Insurance\_\_\_\_\_\_\_ | | | | | |
| Program Requested: | | | | Requested Move-In/Start Date: | |

When you have finished gathering all required information, ask the referral source if they have any other consumers who are in need of services of any kind. Inform them of the other programs we have available. If they have other consumers in need of services, fill out a referral form for them.

Notes: \_Family hires own staff; need to put in writing what is required of staff to be in compliance with 245D requirements \_\_\_\_\_\_

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| **Independence Program Information Only** | |
| Client Name: | PMI#: |
| Client Address: | Client Phone Number:  Video Phone:  Cell: |
| Lives Alone: | Delivery Instructions: |
| Number of Hours, Time of Day, Days of Week:  Unsure of how they want to break it up; waiver says $56,500 to use, 15% needs to be respite | Diet: No restrictions, |
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| **Residential Services/Home Care Information Only** | |
| **Accessibility:** | |
| Wheelchair  Adapted Equipment  Lifts  Ambulatory | |
| Comments: | |
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| **Behavioral/Mental Concerns**: | |
| Self Injurious Behaviors  Aggressive/Violent Behavior Drug/Alcohol Abuse  Criminal History  Rule 40  Felony  Other: | |
| Comments: | |

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| **Personal Cares:** |
| AM/PM Cares  Dressing  Transferring  Bathing/Showering |
| Comments: |

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| **Medical Issues/Diagnoses:** |
| Wound Care  Injections  Seizures Med Set-Up  Med Administration Med Reminders  Diabetic Needs\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: |

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| **Transportation:** Medical  Socialization  Access own transportation  SLS |
| Comments: |

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| **Caregiver Preferences/Other Notes:** |

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| **Program Manager Use Only** | **Program Manager Use Only Home Delivery** |
| Date Received: | Date Received: |
| Call Back Date: | Call Delivery: |
| Sent Checklist Date: | Call Back CM Date: |
| Scheduled Tour Time: | Scheduled Delivery: |
| Fill out Referral Log: | Fill out Referral Log: |
| If not appropriate refer to: | If not appropriate refer to: |