

For SOURCE care coordinators and case management agencies. Please complete what you can and attach the Service Authorization Form (SAF) and care plan. Our referral team reviews every referral to confirm the member's needs fit our services and staffing, then contacts you. Questions: 470-256-3897.

### 1. Referral source (SOURCE case management)

|                                                                     |                                                       |                                              |
|---------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|
| Date of referral<br><input type="text"/>                            | SOURCE case management agency<br><input type="text"/> | SOURCE site / region<br><input type="text"/> |
| Care coordinator / case manager name<br><input type="text"/>        | Phone<br><input type="text"/>                         | Fax<br><input type="text"/>                  |
| Nurse case manager (if different) and phone<br><input type="text"/> |                                                       | Email<br><input type="text"/>                |
| Best time to reach you<br><input type="text"/>                      |                                                       |                                              |

**Referral type:** ☐ New SOURCE member ☐ Transfer from another provider ☐ Added service ☐ Change in units / frequency

**Member chose Von & Bick from the provider list (freedom of choice):** ☐ Yes ☐ No / not yet

### 2. Member information

|                                                |                                                             |                                           |                                                  |
|------------------------------------------------|-------------------------------------------------------------|-------------------------------------------|--------------------------------------------------|
| Member full name<br><input type="text"/>       | Date of birth<br><input type="text"/>                       | Gender<br><input type="text"/>            | Medicaid ID #<br><input type="text"/>            |
| SOURCE enrollment date<br><input type="text"/> | Level of care (LOC) expiration date<br><input type="text"/> | Primary language<br><input type="text"/>  | Interpreter needed (Y/N)<br><input type="text"/> |
| Home address (street)<br><input type="text"/>  | City<br><input type="text"/>                                | County<br><input type="text"/>            | ZIP<br><input type="text"/>                      |
| Member phone<br><input type="text"/>           | Lives with<br><input type="text"/>                          | Lives alone (Y/N)<br><input type="text"/> |                                                  |

**Residence type:** ☐ Private home ☐ Family home ☐ Apartment ☐ Personal care home ☐ Other

### 3. Representative, guardian and emergency contacts

|                                                                   |                                      |                               |                                         |
|-------------------------------------------------------------------|--------------------------------------|-------------------------------|-----------------------------------------|
| Authorized representative / guardian name<br><input type="text"/> | Relationship<br><input type="text"/> | Phone<br><input type="text"/> | Email<br><input type="text"/>           |
| Emergency contact #1 name<br><input type="text"/>                 | Relationship<br><input type="text"/> | Phone<br><input type="text"/> | Alternate phone<br><input type="text"/> |
| Emergency contact #2 name<br><input type="text"/>                 | Relationship<br><input type="text"/> | Phone<br><input type="text"/> | Alternate phone<br><input type="text"/> |

### 4. SOURCE primary care physician

|                                                 |                                                      |                               |                             |
|-------------------------------------------------|------------------------------------------------------|-------------------------------|-----------------------------|
| Physician name<br><input type="text"/>          | Practice / clinic<br><input type="text"/>            | Phone<br><input type="text"/> | Fax<br><input type="text"/> |
| Pharmacy name and phone<br><input type="text"/> | Date of last physician visit<br><input type="text"/> |                               |                             |

### 5. Health information

|                                                                     |                                             |
|---------------------------------------------------------------------|---------------------------------------------|
| Primary diagnosis<br><input type="text"/>                           | Secondary diagnoses<br><input type="text"/> |
| Allergies (medication, food, environmental)<br><input type="text"/> | Special diet<br><input type="text"/>        |

**Mobility:** ☐ Independent ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bed-bound ☐ Hoyer / mechanical lift

**Transfers:** ☐ Independent ☐ Stand-by assist ☐ 1-person assist ☐ 2-person assist

**Continence:** ☐ Continent ☐ Bladder incontinence ☐ Bowel incontinence ☐ Catheter ☐ Ostomy**Cognition:** ☐ Alert and oriented ☐ Mild impairment ☐ Moderate / severe impairment ☐ Dementia diagnosis**Also present:** ☐ Fall risk / recent falls ☐ Oxygen ☐ Diabetes ☐ Seizures ☐ Wounds / pressure injury☐ Behavioral health needs

Recent hospitalizations / ER visits (dates, reason)

## 6. SOURCE services requested

Check each service authorized or requested. Personal Support Services (PSS) visits are up to 11 units (15 minutes each); Extended Personal Support (PSSX) visits are 12 units or more.

| Service                          | Requested                | Units per visit      | Visits per week      | Days / times preferred |
|----------------------------------|--------------------------|----------------------|----------------------|------------------------|
| Personal Support Services (PSS)  | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   |
| Extended Personal Support (PSSX) | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   |
| In-home respite                  | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   |
| Skilled nursing (if authorized)  | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   |
| Other:                           | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/>   |

Requested start date

Authorization / SAF number

Authorization dates (from – to)

## 7. Personal support tasks needed

**Personal care:** ☐ Bathing ☐ Dressing ☐ Grooming / hygiene ☐ Toileting / incontinence care ☐ Transfers ☐ Walking☐ Eating / feeding**Home support:** ☐ Meal preparation ☐ Light housekeeping ☐ Laundry ☐ Shopping / errands ☐ Medication reminders☐ Escort to appointments ☐ Companionship / supervision

Other tasks or special instructions

## 8. Home environment and staff safety

**Home:** ☐ Stairs / steps ☐ Pets ☐ Smoking in home ☐ Oxygen in use ☐ Accessible bathroom

Pets (type) and how to enter the home

Any safety concerns for staff

**Caregiver preference:** ☐ No preference ☐ Female ☐ Male ☐ Language:

## 9. Documents attached

**Attached:** ☐ Service Authorization Form (SAF) ☐ Comprehensive Care Plan ☐ MDS-HC / assessment ☐ Face sheet☐ Medication list ☐ Physician orders ☐ LOC documentation

## 10. Care coordinator attestation

I confirm the member (or representative) chose Von & Bick Healthcare Associates as their provider and agreed to this referral, and the information above is accurate to the best of my knowledge.

| Role                            | Printed name         | Signature            | Date                 |
|---------------------------------|----------------------|----------------------|----------------------|
| Care coordinator / case manager | <input type="text"/> | <input type="text"/> | <input type="text"/> |

### Send this referral

Fax: 770-637-3386 · Email: [lkindler@vbhealthcare.org](mailto:lkindler@vbhealthcare.org), [casey.ross@vbhealthcare.org](mailto:casey.ross@vbhealthcare.org) or [trudy.lee@vbhealthcare.org](mailto:trudy.lee@vbhealthcare.org) · Office: 470-256-3897.  
Please send by fax or secure, encrypted email only.

### Office use only — VBHC referral team

Date / time received

Received by

Reviewed by (referral team)

Decision date

**Decision:** ☐ Accepted ☐ Declined ☐ More information needed ☐ Waitlist

Reason / notes

Coordinator notified (date, by whom)

Intake visit date

Service start date

Assigned staff

Nursing assessment date