TRANSITION REFERRAL FORM

Date of Referral _____

Instructions: Fill out the entire form and email a scanned copy along with the Face Sheet to achristopher@accesstoindependence.org or fax the documents to Andrea Christopher at (619)704-2054.

CONSUMER INFORMATION

Name _____

Phone No. _____

Email _____

Address_____

Date of Birth_____

Monthly Income_____

Admission Date _____

Reason for Admission _____

Estimated Discharge Date _____

Primary Diagnosis/Disability _____

Medi-Cal/Medicare/Both _____

Does Consumer have a plan for housing After discharge? _____

FACILITY INFORMATION

Facility Name _____

Facility Contact Name & Title _____

Phone No. _____

Email _____

CONSUMER DISCHARGE NEEDS (check all that apply)

- ☐ 1st-month's rent
- ☐ 1st month's utilities
- ☐ Retrieval of items in storage
- ☐ Initial stock of groceries
- ☐ Basic Clothing
- ☐ Basic Furniture
- ☐ Moving Expenses
- ☐ Home Modifications
- ☐ Other: _____
- ☐ Personal items (toiletries, medical supplies, etc)
- ☐ Household items (pots/pans, dishes, towels, bedding, etc)
- ☐ Occupational Therapy assessments
- ☐ Physical Therapy assessments
- ☐ Assistive Technology assessments
- ☐ Caregiving services
- ☐ Assistive Technology _____
- ☐ Assistive Technology _____
- ☐ DME (not covered by insurance) _____

ADDITIONAL INFORMATION

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