Alpha HealthPlus RSA Referral Form.

10055 Red Run Blvd, Suite 190, Owings Mills, MD 21117| Tel: (410) 374-7686 Admin@alphahealthplus.com
]www.alphahealthplus.com.

Section 1: Client Demographics

Full Name: _____
Date of Birth: ____ / ____ / _____
Age: _____
Gender Identity: ☐ Male ☐ Female ☐ non-binary ☐ Other: _____
Preferred Language: _____
Race/Ethnicity: _____
Phone Number: _____
Email Address: _____
Current Address: _____
City: _____ **State:** _____ **ZIP Code:** _____
Social Security Number (Last 4 Digits): _____

Section 2: Referral Source Information

Referring Agency/Organization: _____
Contact Person Name: _____
Position/Title: _____
Phone Number: _____
Email Address: _____
Relationship to Client: _____
Date of Referral: ____ / ____ / _____

Section 3: Insurance & Benefits

Medicaid Number: _____
Medicare Number: _____
Other Insurance (Private/Managed Care): _____
Is client currently receiving:
☐ SSDI ☐ SSI ☐ TCA ☐ SNAP/Food Stamps ☐ Housing Voucher ☐ None
Needs Assistance with:
☐ Insurance Application ☐ Benefit Reinstatement ☐ Redetermination

Section 4: Medical & Psychiatric Information

Primary Medical Diagnosis(es):

_____

Psychiatric Diagnosis(es) (if applicable):

_____

Current Medications (Name/Dose/Frequency):

_____

Primary Care Provider (PCP):
Name: _____ Phone: _____

Psychiatrist (if any):
Name: _____ Phone: _____
Recent Hospitalizations:
☐ No ☐ Yes – Please provide name of hospital, dates, and reason:

Section 5: Functional & Behavioral Status

Cognitive Impairments (if any):
☐ Memory ☐ Orientation ☐ Communication ☐ None
Notes: _____
Mobility Status:
☐ Independent ☐ Needs Assistance ☐ Uses Wheelchair/Walker
Behavioral Concerns:
☐ Self-Injury ☐ Aggression ☐ Elopement ☐ Non-Compliance ☐ None
Description: _____
ADL Support Needs (Activities of Daily Living):
☐ Bathing ☐ Dressing ☐ Toileting ☐ Feeding ☐ Grooming ☐ Medication Admin
☐ Meal Preparation ☐ Light Housekeeping ☐ Community Integration

Section 6: Requested Services

Check all services being requested from Alpha HealthPlus RSA:
☐ In-Home Personal Care Assistance
☐ Medication Administration by CMT
☐ Nursing Oversight (RN Visits)
☐ Behavioral Health Monitoring
☐ Assistance with ADLs/IADLs
☐ Transportation Coordination
☐ Companionship
☐ DME/Home Safety Evaluation
☐ Other: _____

Section 7: Consent and Authorization

☐ I consent to the release of this information to Alpha HealthPlus RSA to determine eligibility for services.
☐ I certify that the information provided is accurate to the best of my knowledge.
Client/Guardian Signature: _____
Date: ____ / ____ / _____
Referring Party Signature: _____
Date: ____ / ____ / _____

Section 8: Office Use Only

Date Received: ____ / ____ / _____
Assigned Case Manager/Nurse: _____
Initial Review Completed by: _____
Date of Intake Scheduled: ____ / ____ / _____