allcare pace

Program of All-inclusive Care for the Elderly

Referral Information

1. To refer a potential client to AllCare PACE, please complete this form and fax it to (541) 474-3296 or email to **PACEEnrollment@allcarehealth.com** — Subject: **Referral**.
2. Along with the referral form please fax or email the **SDS002N**.
3. An AllCare PACE Intake & Referral Specialist will contact the individual or identified contact person to explain the program and answer questions. If the person meets the eligibility criteria and is interested in our program they will proceed through the intake assessment.
4. If you or your client have questions at any time during this process call us at (541) 474-8000 or e-mail at **PACEEnrollment@allcarehealth.com.**

Your Information

Name: _____ Date:_____

County/Branch:_____ Department: _____

E-Mail: _____ Phone #:_____

Client Information

Name: _____ DOB: _____ Phone #:_____

Address: _____

E-Mail: _____ Current LIving Situation: _____

SPL: _____ SSN: _____ Identified Gender: _____

Medicaid #: _____ ALF Level: _____ RCF/AFH Level: _____

Medicare/MBI #: _____ Part A: _____ Part B: _____

Rate Exception? _____ Exception Amount: _____ In Home Hours: _____

Reason for requesting AllCare PACE? _____

Special Needs/Additional Notes/Reason for Add-ons:_____

_____

_____

Has the referral been discussed with the client?_____

Contact Information (if not the client)

Primary Contact:_____ Relationship:_____

POA HC: _____ POA Fin: _____

Phone #: _____ E-Mail:_____

Certified B Corporation

An Oregon Benefit Company

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