## Referral Information

1. To refer a potential ElderPlace Participant, please complete this form and fax it to 503-215-7985 or e-mail to ElderPlaceinfo@providence.org – **Subject: Medicaid Referral**
2. Along with the referral form please fax/e-mail the SDS002N
3. An ElderPlace Information and 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 be contacted by an Intake and Enrollment specialist.
4. If you or your client have questions at anytime during this process call us at 503-215-6556 or e-mail at ElderPlaceinfo@providence.org

## Your Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |       |  | Date: |       |
| County: |       |  | Department: |       |
| E-Mail Address: |       |  | Phone No: |       |

## Client Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | DOB |       |
| Address Street, City, State, Zip |       |
| Phone #/E-Mail |       |
| Current Living Situation |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| SPL |       | SSN |       | Identified Gender |       |
| Medicaid # |       | ALF Level |       | RCF/ACH Level |       |
| Medicare # |       | Part A |       | Part B |       |
| Rate Exception? |       | Exception Amount? |       | In Home Hours |       |

|  |
| --- |
| Reason for requesting ElderPlace?      |
| **Reason for Add-on**/Special Needs/Additional Notes      |
| Has the referral been discussed with the Client?       |

## Contact Information (if not the client)

|  |  |
| --- | --- |
| Primary Contact |       |
| Relationship |       | POA HC |       | POA Fin |       |
| Phone Number |       | E-mail |       |