



Referral Form

DePaul Community Services - 55 and Over Supportive Housing Program

UPDATED 6/19/2020

Resident Name: _____ Referral date: ____ / ____ / ____

Resident Phone #: _____ Date of birth: ____ / ____ / ____

Gender Identity: Male Female Other: _____

Current Address: _____

Social Security #: _____ **Medicaid #:** _____

Referral Agency: _____ Referred by: _____

Phone #: _____ Email: _____

Preferred Language: _____ Interpreter needed for intake? Yes No

Emergency Contact: _____ Relationship: _____

Phone#: _____ Email: _____

Does the prospective resident have any therapy animals? Yes No

- If yes, does the prospective resident have documentation for the animal? Yes No

Eligibility Determination: Service eligibility includes any person who is age 55 and older, who is enrolled in Medicaid, and requires assistance with two or more activities of daily living. Must be referred from one of the following:

Which category of organization is making the referral?

- Health home Hospital Managed care organization Managed long term care
- Medical respite Shelter Skilled nursing facility Preferred provider system

Is Medicaid currently active? Yes No - *If no, is application pending?* Yes No

With which home management activities does the person need assistance?

Please describe current situation and what led to the need for assistance:



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Medical Doctor:

Agency: _____
Phone #: _____

Other Clinical/Medical Provider:

Agency: _____
Phone #: _____

Other Clinical/Medical Provider:

Agency: _____
Phone #: _____

Other Clinical/Medical Provider:

Agency: _____
Phone #: _____

Risks *(please check all that apply and note date of occurrence if appropriate):*

- Engaged in arson *(date: ___ / ___ / ___)*
- Destruction of property *(date: ___ / ___ / ___)*
- Sexual offenses toward others *(date: ___ / ___ / ___)*
- Violent criminal offenses toward others or property *(date: ___ / ___ / ___)*
- Physical harm to others *(date: ___ / ___ / ___)*
- Suicide attempt/self injury *(date: ___ / ___ / ___)*
- Victim of physical or sexual abuse *(date: ___ / ___ / ___)*

Additional comments: _____

Medical Issues *(please check all that apply):*

- History of falls
- Incontinence
- Hearing loss
- Vision loss

Impaired ability to walk? Yes No

- If yes, the resident uses a (please check all that apply): Walker Wheelchair Transfer chair

Allergies: _____

Additional comments: _____



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Please complete the following regarding the resident's ability and/or willingness to:

Manage their personal needs (*grooming, hygiene, laundry, cleaning, etc.*): _____

Manage their own money: _____

Respond appropriately to emergency situations (*i.e. fire*): _____

Use their own transportation, public transportation and other community resources: _____

Plan, shop and prepare meals: _____

Follow through with appointments and other responsibilities: _____

Comply with medication regimen:

- Is resident self-medicating? Yes No - *If no, are supports in place to assist?* Yes No

- Filling their own prescriptions? Yes No - *If no, are supports in place to assist?* Yes No

Please describe the resident's previous:

Independent living experience: _____

Drug/alcohol history if relevant (*How long abusing?*

How long sober?): _____

Interpersonal skills/social support system (*including family*): _____

Most recent hospitalization (*please include dates and causes*): _____



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Funding (please check all sources of income recipient currently receives):

- | | |
|--|---|
| <input type="checkbox"/> SSI - \$_____ per month | <input type="checkbox"/> Alimony - \$_____ per month |
| <input type="checkbox"/> SSD - \$_____ per month | <input type="checkbox"/> Employment - \$_____ per month |
| <input type="checkbox"/> SSP - \$_____ per month | <input type="checkbox"/> Pension - \$_____ per month |
| <input type="checkbox"/> DHS - \$_____ per month | <input type="checkbox"/> Trust Fund - \$_____ per month |
| <input type="checkbox"/> SNAP Benefits - \$_____ per month | <input type="checkbox"/> Other - \$_____ per month |

Medicare? Yes No

Medicaid? Yes No - If yes, Medicaid #: _____

Representative Payee? Yes No - If yes, which agency: _____

Assets (please list all other assets): _____

This potential resident is medically and psychiatrically stabilized, does not need a higher level of care and is considered appropriate for the 55 and Over Supportive Housing Program. To the best of my knowledge, the potential resident meets the eligibility criteria listed above.

Signature of Referral Agent: _____ Date: ____ / ____ / ____
SIGNATURE REQUIRED

Print name and title: _____

Signature of Resident: _____ Date: ____ / ____ / ____
SIGNATURE REQUIRED

Print name: _____

Completed referrals can be submitted to:
La Rosa Villas
43 Mill Street, LeRoy, NY 14482
Email: larosavillas@depaul.org
Phone: 585-417-1220 Fax: 585-768-2099