Referral Form
DePaul Community Services - 55 and Over Supportive Housing Program

UPDATED 12/17/2020

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: _____ Interpretor 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:

_____

_____

_____

_____

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: _____

_____

_____

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)*:

- ☐ SSI - $_____ *per month*
- ☐ SSD - $_____ *per month*
- ☐ SSP - $_____ *per month*
- ☐ DHS - $_____ *per month*
- ☐ SNAP Benefits - $_____ *per month*
- ☐ Alimony - $_____ *per month*
- ☐ Employment - $_____ *per month*
- ☐ Pension - $_____ *per month*
- ☐ Trust Fund - $_____ *per month*
- ☐ 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:

Apple Blossom Apartments

2228 Old Union Road, Cheektowaga, NY 14227

Email: appleblossomapartments@depaul.org