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

UPDATED 4/13/2023

**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*

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**Eligibility Determination:** Service eligibility includes any person who is age 55 and older, who is enrolled in Medicaid, has documented proof of a chronic condition, 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*

**Medical/Chronic Conditions:** _____

_____

_____

**Allergies:** _____

_____

_____

**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)*: _____

**Please be sure to include the following documents (if available) so there is no delay in processing your application.**

- ☐ 1. Medical evaluation by a licensed provider (annual physical, etc.)
- ☐ 2. Hospital admission/discharge reports (dated within the past year)

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:

Program Manager

27 Church Street, Port Byron, NY 13140

Email: portbyron@depaul.org

Phone: (518) 267-1150 Fax: (315) 776-3111