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

UPDATED 4/23/2026

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, 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: ____________________

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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)*:

- ☐ 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

536 Central Avenue, Rochester, NY 14605

Email: truenorth@depaul.org

Phone: 585-312-7460