

Community Living Connections Referral Form

Referring Agency Name: _____
 Staff Name Completing Form: _____
 Staff Contact Information (if follow up desired): _____
 Referral Date: _____

Fax completed forms to 206.436.2972
 or send via *secure* email to
 info@communitylivingconnections.org

CLIENT INFORMATION *required field

*Client Name: _____ *Age: _____ Gender: _____ *Zip Code: _____
 Insurance: Medicaid Medicare Private/Other None Net Monthly Income: _____
 Veteran: Yes No Household Size: _____ Needs Interpreter: Yes No
 *Primary Contact Info: _____ Secondary Contact Info: _____
 *Preferred Language: _____ Race/Ethnicity: _____

If someone is helping the client (friend, family, case manager/social worker), complete the following:

Support Person: _____ Need Caregiver Support? Yes No
 Relationship: _____ Preferred Phone Number or Email: _____

UNMET NEEDS IDENTIFIED / REASON FOR REFERRAL

- | | |
|---|---|
| <input type="checkbox"/> Access to Food | <input type="checkbox"/> Help with ADLs - Activities of Daily Living (<i>specify below</i>) |
| <input type="checkbox"/> Housing Assistance | <input type="checkbox"/> Help with IADLs - Instrumental Activities of Daily Living (<i>specify below</i>) |
| <input type="checkbox"/> Transportation Information | <input type="checkbox"/> Home Safety Concerns or Fall Risk |
| <input type="checkbox"/> Financial Concerns | <input type="checkbox"/> Alzheimer's Disease and Dementia Resources |
| <input type="checkbox"/> OTHER (please explain) | |

Please indicate any other support services client or caregiver is receiving or has been referred to:

Individual consents to the use of confidential information about them to plan, provide, and coordinate services, payments, and benefits or for other purposes authorized by law. Individual further grants permission to agencies, providers, or persons to use confidential information and disclose it to each other for these purposes. Information may be shared verbally or electronically, mail, or hand delivery. *Individual has been informed that they will be contacted by Community Living Connections and consents to this contact.*

Staff Witness Name: _____

Date of Consent: _____

