BENZIE SENIOR RESOURCES
REFERRAL FORM

Referral Date:			
GENERAL CLIENT INFORMATION			
Name:			Goes By:
Address/PO Box:			
City:	Township:	Zip:	Phone:
DOB:	Age:	Race: ☐ White ☐ Native American ☐ Asian ☐ Hispanic ☐ Black/African American ☐ Other	
☐ Male ☐Female Veteran: ☐ Yes ☐ No Spouse of a Veteran: ☐ Yes ☐ No			
Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Widowed ☐ Single ☐ Other			
Currently Residing At: ☐ Home ☐ Nursing Home ☐ Hospital ☐ Other			
Name of Nursing Home, Hospital & Other:			
Usual Living Arrangements: ☐ Alone ☐ W/Spouse ☐ W/Family ☐ Other			
Name of Person(s) Living With:			
Medicare: ☐ Y ☐ N	Medicaid: ☐ Y ☐ N	LTC Insurance: ☐ Y ☐ N	Other: ☐ Y ☐ N
Other Insurance Coverage:			
Housing: ☐ Home ☐ Mobile Home ☐ Apartment ☐ Other			☐ Rent ☐ Own
Pets in home: ☐ Yes ☐ No		☐ Cats #:	☐ Dogs #:
Email Address:			
REFERRAL SOURCE			
Name & Title:			Relationship:
Hospital/Agency Name:			
Address/PO Box:			
City:	State:	Zip:	Phone:
EMERGENCY CONTACT			
Name:			Relationship:
Address/PO Box:		City:	Zip:
Email Address:			Phone:
Name:			Relationship:
Address/PO Box:		City:	Zip:
Email Address:			
PERSONAL HEALTH HISTORY			
Hospitalization Admission in Last 90 Days: ☐ Yes ☐ No			
Hospital Name:			Dates of Hospital Stay:
Reason for Admission:			
Allergies:			
Allergies:			
Difficulties In: ☐ Hearing ☐ Sight ☐ Speech ☐ Mobility ☐ Memory Loss/Confusion			
If √, Explain:			

Medical Conditions: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Depression		
☐ Arthritis ☐ Stroke ☐ Oxygen Use ☐ Parkinson's ☐ Cancer ☐ Dementia ☐ Other		
If √, Explain:		
If √, Explain:		
Do you have Durable Power of Attorney for Healthcare, such as 5 Wishes? :☐Yes ☐ No		
Other Medical Condition/History Comments:		
MEDICAL PROVIDER/SPECIALTY		
1):	Last Appt:	Phone:
2):	Last Appt:	Phone:
REQUESTED SERVICES		
☐ HOME DELIVERED MEALS ☐ HOMEMAKING ☐ HOME HEALTH CARE		
HOME DELIVERED MEAL PROGRAM		
Is the client: ☐ Homebound ☐ Unable to get groceries ☐ Unable to prepare meals		
Diabetic: ☐ Yes ☐ No If Yes, is Diabetes controlled by: ☐ Diet ☐ Medication ☐ Insulin		
Available Meals: ☐ Hot Meal ☐ Cold Meal ☐ Frozen ☐ Breakfast Bag		
Explain that HDM Coordinator will be calling with additional questions related to the qualifications, meals and delivery process. Costs of HDM meals is based on a suggested donation of $3 and no one is denied the meal based on their inability to donate.		
Additional Comments/Notes:		
HOMEMAKING PROGRAM		
Limitations that Prevent Cleaning House:		
Requested Help: ☐ Laundry ☐ Clean bathroom ☐ Change Bed Linens ☐ Vacuum		
☐ Dusting ☐ Clean kitchen ☐ Do Dishes ☐ Sweeping/Mopping Floors		
Explain the cost share of the Homemaking Program and that we will need to review the total gross household income when the nurse comes out to conduct the assessment. Explain how the vouchers work and HM contractors.		
Additional Comments/Notes:		
IN-HOME CARE SERVICES		
Requested Help: ☐ Bathing/Shower ☐ Meal Prep ☐ Dressing ☐ Ambulation Assist		
☐ Grooming/Hair Care ☐ Toileting Needs ☐ Respite Care ☐ Grocery Shopping/Errands		
Other help:		
Explain the cost share for the In-Home Care Program and that we will need to review the total gross household income when the nurse comes out to conduct the assessment.		
Additional Comments/Notes:		
Other Requested Services:		
Name of Person taking the Referral:		
Referral Given To:	Date:	