CFC/PAS MEMBER REFERRAL

☐ AB-CFC ☐ SD-CFC ☐ ABPAS ☐ SDPAS

☐ Initial ☐ Readmission ☐ Short Term ☐ Change

Medicaid ID#	Last Name	First Name		DOB
Street Address	City	Zip	Home Phone	Cell Phone
Mailing Address	City	Zip	Message Phone	

RESPONSIBLE PARTY

Name	□ Member □ Legal Guardian □ Personal Representative (SD only – if other than member) □ Contact Person (AB only - if other than member)			
Street Address	City	Zip	Home Phone	Cell Phone
Mailing Address	City	Zip	Work Phone	

☐ **CHANGE IN OPTION** *(select one):* ☐ AB-CFC to SD-CFC ☐ SD-CFC to AB-CFC ☐ ABPAS to SDPAS ☐ SDPAS to ABPAS ☐ PAS to CFC (evaluate LOC)

NEW PERSONAL REPRESENTATIVE (PR) INFORMATION: Name: Address: Phone: Reason for new PR:	**CHANGE IN AGENCY** New Agency Name: Agency Representative: Phone:

Directions to home and other pertinent information:

PERSONAL CARE NEEDS

☐ Bathing ☐ Dressing ☐ Hygiene	☐ Toileting ☐ Transfer ☐ Position	☐ Mobility ☐ Meal ☐ Eating	☐ Exercise ☐ Medication Reminder ☐ PERS	☐ IADLs (Describe):

COMMENTS RELATED TO PERSONAL CARE NEEDS:

HEALTH MAINTENANCE ACTIVITIES (Self Direct referrals only)

☐ Urinary Systems Management ☐ Bowel Care ☐ Medication Administration ☐ Wound Care

HEALTH CARE PROFESSIONAL

Health Care Professional Name:	**Telephone:**

LIST EACH RELEVANT MEDICAL DIAGNOSIS

REFERRAL SOURCE

Name Address	Agency City	Phone Zip	Fax Date

HIGH RISK

High Risk Referral? ☐ Yes ☐ No Reason?

Date Services Instituted:
Number of Days Biweekly (Every Two Weeks) : ____ Number of Units Biweekly (Every Two Weeks): __
1 unit = 15 Minutes