

## Information & Assistance Referral Form

*Information, Assistance and Referral services support all older persons 60+ and their caregivers in assessing their needs, identifying the most appropriate services to meet their needs and linking the older person and caregiver to the agencies providing these services.*

Asterisk (\*) denotes required fields

### Client Information

Client Name\*

Date of Birth\*

Medicaid Number

Medicare Number

Social Security Number

Male

Female

Client Phone #\*

County of Residence: \_\_\_\_\_

Street Address

City, State, Zip

Caregiver Name

Caregiver Phone Number

Relationship to Client

Contact Name (if different from Caregiver)

Contact Phone Number

Relationship to Client

Referral Source Name

Phone Number

Relationship to Client

Client Diagnosis: \_\_\_\_\_

### Services Requested:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Adult Day Care       | <input type="checkbox"/> Alzheimer's Dementia Program | <input type="checkbox"/> Caregiver Support                                | <input type="checkbox"/> Consumer Directed Care |
| <input type="checkbox"/> Home Delivered Meals | <input type="checkbox"/> Homemaker Services           | <input type="checkbox"/> Legal Services                                   |   |
| <input type="checkbox"/> Respite Care         | <input type="checkbox"/> Transportation               | <input type="checkbox"/> Emergency Assistance (Utility/Pest Control/etc.) |   |
| <input type="checkbox"/> Other: _____         |   |   |   |

Additional Pertinent Information: \_\_\_\_\_

For more information contact:

I&R Coordinator



(228) 868-2311



mac@smpdd.com