FAX to Greater Springfield Senior Services, Inc. 413-328-6345

Name of Person Submitting Form:

_____

Date Submitted : _____ / _____ / _____

Program being Requested:

☐ **Home Delivered Meals**
(must be age 60 or over, not a PCA client)

☐ **State Home Care**
(must be age 60 or have Alzheimer's Dx.)

☐ **Personal Care Attendant Program**
(any age, must have MassHealth Standard or CommonHealth)

☐ **Long-Term Care Nursing Home Screen**
(any age, must have MassHealth Standard)

☐ **Adult Day Health Screen**
(any age, must have MassHealth Standard or CommonHealth)

☐ **Family Caregiver Support Program**
*(must have an active caregiver; referral must be made in **caregivers name;** the caregiver is the "Consumer.")*

☐ **Long Term Care Options Counseling**
*(the Consumer cannot be an **active** SHC, SCO or AFC client)*

Referral Source:

Name: _____

Title: _____

Agency: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Ext: _____

Cell: _____

Fax: _____

Consumer being referred:

Name: _____

Address: _____

City: _____ Zip: _____

Phone: _____

Cell: _____

DOB: _____ Gender: _____

Marital Status: _____ Lives Alone? _____

Veteran: ____

MassHealth ID #

_____

Primary Language: _____

Primary Emergency Contact/Caregiver:*
**Must be filled out completely if making a PCA, AFC Nursing Screening or Family Caregiver Support Program Referral*

Name: _____

DOB: _____

Relationship/Agency: _____

HCP: _____ POA: _____ Guardian: _____

Address: _____

Apt. #: _____ P.O. Box: _____

City/State: _____ Zip: _____

Home #: _____ Work: _____

Cell #: _____

Reason for referring – Why services are needed:

_____

_____

_____

_____

Primary Care Physician:

Name: _____

Medical Office: _____

Address: _____

City: _____ Zip: _____

Phone: _____ Ext: _____

Fax: _____ PCC#: _____

Is a VNA currently in-home? **_____**

If so, which VNA? **_____**

Any other Services currently in-home? **_____**

If so, what Services **_____**

Consumer's Medical HX/DX:

ADDITIONAL NOTES: