COMMUNITY OUTREACH PROGRAM
RESOURCES FOR THE ELDERLY AND DISABLED
Office (888) 832-1550 ♦ Spanish Support (404) 214-9852 ♦ Fax (404) 873-6818

OFFICE USAGE ONLY: Date Faxed [ ] To _____

Date Referral received: _____ Referred by: _____Office Location _____

Referral Source: Employee ( ) Office Staff ( ) Name _____

Unspecified direct call to office ( ) From Agency Name _____

To complete the screening we should contact the: Applicant ( ) Contact Person ( ) other: _____

APPLICANT INFORMATION

Applicant's Name: _____ Phone: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ Monthly Income: _____

Birth Date: _____ Age: _____ Does Applicant live alone? Yes ( ) No ( )

Social Security #: _____ Medicaid #: _____ Applied for Medicaid: Yes ( ) No ( )

Major Health Problems: _____

CONTACT PERSON INFORMATION

Contact Person: _____ Relationship: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

PHYSICIAN INFORMATION

Applicant's Physician: _____ Phone: _____

SERVICES NEEDED

Type of help needed: _____

Information Needed: _____

Services Applicant is receiving now: _____

Agency providing those services: _____

I authorize Caring Hands United, Inc and referring agencies to disclose personal health and financial information for the purpose of determine eligibility for Medicaid Waiver Programs, notifying emergency contacts in the event of an emergency, contacting referral sources and contact person listed above, and as allowed by law in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Applicant/Proxy Signature: _____ Date: _____