Washington State Department of Social & Health Services
Transforming lives

HOME AND COMMUNITY SERVICES (HCS)

Adult Day Service Referral

All fields are required unless "optional" is indicated in the field.

1. REFERRAL TO:

2. REFERRED FROM: ☐ HCS ☐ AAA

3. DATE OF REFERRAL

4. PROVIDER AUTHORIZATION NUMBER

5. CLIENT'S NAME (LAST, FIRST, MIDDLE INITITAL)

6. DATE OF BIRTH

7. PHONE NUMBER (AND AREA CODE) ( )

8. ACES ID NUMBER

9. CLIENT'S ADDRESS: STREET CITY STATE ZIP CODE

10. PRIMARY CAREGIVER'S NAME OR AGENCY NAME

11. PHONE NUMBER OF AGENCY ( )

12. REFERRED PROGRAM

☐ Adult Day Care ☐ Adult Day Health ☐ To be determined at the center

13. REASON FOR REFERRAL

☐ Unstable / potentially unstable diagnosis

Client has one or more of the following diagnoses (check all that apply):

☐ Diabetes ☐ CHF ☐ COPD ☐ Recurrent UTI's ☐ Edema ☐ Dementia
☐ Obesity ☐ Stroke ☐ ALS ☐ Parkinson's ☐ TBI ☐ MS
☐ Other:

☐ Medication regimen affecting plan of care

☐ Mobility issues affect plan of care

Client has one or more of the following conditions (check all that apply):

☐ Poor balance ☐ Poor transfers ☐ Fall history ☐ Deconditioning
☐ Unsteady gait ☐ Poor hand / eye coordination ☐ Limited ROM
☐ Uses wheelchair ☐ Uses walker ☐ Uses cane

☐ Current or potential skin problem

☐ Nutritional status affecting plan of care

☐ Other:

14. REQUESTED ACTIVITY (CHECK ALL THAT APPLY)

☐ Nursing Assessment ☐ OT Assessment ☐ PT Assessment ☐ Speech Assessment
☐ Audiology Assessment ☐ Social Work consult ☐ Rehab Assessment
☐ Other:

15. ADDITIONAL INFORMATION

16. REFERRING CASE MANAGER'S NAME

TITLE

PHONE NUMBER (AND AREA CODE) ( )

FAX NUMBER (AND AREA CODE) ( )

EMAIL ADDRESS

IMPORTANT: Please be sure to fax or email current CARE Assessment with referral

Confirmation of Acceptance

☐ Referral received; date received:

☐ Referral accepted

☐ Referral not accepted; reason(s):

Adult Day Service Referral Instructions

All fields are required unless "optional" is indicated in the field.

1. Referral To: Enter the adult day centers name.
2. Referred From: Identify what office the referral is being sent from.
3. Date of Referral: Enter date referral was sent to adult day center.
4. Provider Authorization Number: Enter approved adult day center authorization number.
5. Client's Name: Enter client's full name (last, first, and MI).
6. Date of Birth: Enter client's date of birth (month, day, and year).
7. Telephone Number: Enter client's telephone number, include area code.
8. ACES ID: Enter clients ACES ID.
9. Client's Address: Enter client's physical address (house address, city, state, zip code).
10. Primary Caregiver's Name or Agency Name: Enter the name or agency name of client's primary caregiver.
11. Telephone number of Agency: If an agency is the client's primary caregiver, list the agency phone number, include area code.
12. Referral Program: Identify which program the client's is being referred to. If unable to determine, check "to be determined at the center."
13. Reason for Referral: Identify why the client is being referred to adult day services. If reason is not identified on the referral form, indicate why under "other".
14. Requested Activity: Identify what activity the client is being referred for. If reason is not identified on the referral form, indicate what activity under "other".
15. Additional Information: Enter additional information which is pertinent to the clients care or useful for the adult day center to know.
16. Referring Case Manager's Name / Title, Phone, Fax number, and Email address: Enter the name and title of the referring case manager with contact information (telephone, fax, and email address).

Confirmation of Acceptance: The adult day center will respond to the referral within two business days, acknowledging receipt of referral as illustrated by a date and response.