



HOME AND COMMUNITY SERVICES (HCS)  
**Adult Day Service Referral**

1. REFERRAL TO:	
2. REFERRED FROM: <input type="checkbox"/> HCS <input type="checkbox"/> AAA	3. DATE OF REFERRAL
4. PROVIDER AUTHORIZATION NUMBER	

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

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