Senior Resource Alliance

Referral Form

(407) 514-1800 / (407) 228-1835 Fax

SRA/ADRC Use only Refer ID

Referral Source (Name/Organization Name): Date Completed:	Name of individual completing this Referral: _____ Email address:_____ Phone _____ Fax_____	
Name of client:	Social Security # (optional):	DOB:
Current Physical Address:		
Current Physical Location Type (Circle): RESIDENCE HOSPITAL ASSISTED LIVING OTHER:		
Zip Code:	County:	
Phone number:	Alt. phone number, if applicable:	
Person to be contacted:	Best time to call:	Language Spoken:

Please mark Assistance / Services Needed:

- ☐ Community Statewide Medicaid Managed Care Long-Term Care
- ☐ Home Delivered Meals
- ☐ In-home Assistance (Homemaking/Personal Care)
- ☐ Respite for a Primary Caregiver
- ☐ Telephone Reassurance Calls
- ☐ Mental Health Counseling
- ☐ Medicare Counseling

Is the client currently receiving any services? ☐ Yes ☐ No	If yes, what services?

Does client have capacity to consent? ☐ Yes ☐ No

If yes, client must sign consent section. If no, authorized representative must complete the Authorized Representative of Client Notice of Consent.

Client Notice of Consent

By signing this document you (the client) confirm you are aware of and are authorizing a referral for information or assistance to be submitted on your behalf and allow Senior Resource Alliance *staff to contact you directly regarding this request:*

Client Name:_____

Client Signature: _____ **Date:**_____

Authorized Representative of Client Notice of Consent

By signing this document you (the legal authorized representative of the client) confirm you are aware of and are authorizing a referral for information or assistance to be submitted on your behalf and allow Senior Resource Alliance *staff to contact you directly regarding this request:*

Client Name:_____

Client Signature: _____ **Date:**_____