Community Partners Referral Form

Please fill in the blanks where applicable

Applicant Information					
Has clients rights, responsibilities and release of information been clearly explained to client?					
Name:					
Date of birth:	Gender:	Phone:			
Current address:					
City:	State:	ZIP Code:			
County:	Primary Language:				
Does Client have Medicare?	**Yes**		**No**		
Does Client have Medicaid?	**Yes**		**No**		
Does Client have a Social Security Number?	**Yes**		**No**		
Does Client Have Legal Guardian? (if applicable)	**Yes**		**No**		
Has Client been discharged from a hospital or nursing facility? (if yes please include release date)					
Is this client being referred due to answering YES through the MDS 3.0 SECTION Q question?					

Referring Agency			
Agency:			
Agent:			
Phone:	E-mail:	Fax:	
Referral Date:			

Emergency Contact			
Name of a person not residing with you:			
Address:			
City:	State:	ZIP Code:	Phone:
Relationship:			

Services
Current services client is receiving from your agency:
Services client is requesting:
Additional comments:

Client Consent				
Has client consented to release information between community partners?	Yes		No	
Has client received and signed HIPPA privacy information acknowledgment form?	Yes		No	

This section is to be completed by receiving agency and to be returned to Referring Agency within 30 days of initial referral.		
Agency:	Agent:	Phone:
Case Status:		

Please Email Referral form to: Rio-NetADRC@LRGVDC.ORG

or

Please print and fax this form to (956) 682-8852 (Attention Rio-Net ADRC staff)

Click Here to Print!