 

Referral for Services

***\*\*Anything in bold and italics is required information.***

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| --- | --- |
| ***Participant Name:*** |  |
| Participant Date of Birth: |  |
| Participant Address: |  |
| ***County of Residence:*** |  |
| ***Participant Phone Number:*** |  |
| Does the Participant Have Medicare and/or Medicaid (Check Box): | Medicare Medicaid |
| ***Caregiver Name (if applicable):*** |  |
| ***Caregiver Phone Number:*** |  |

Interested in (please check one): PACE or DayBreak

Whom should Total Senior Care Intake Staff contact? (please check one):Participant orCaregiver

***Is the Participant and/or Caregiver aware of this referral?  Yes  No***

***Is the Participant and/or Caregiver agreeable to Total Senior Care calling them?  Yes  No***

Please fax this form to Total Senior Care at (716) 379-8543, attention: Intake Staff

Referral form may also be submitted by mail: 519 N. Union Street Olean, NY 14760

Referral Source/Name:

Referral Source/Phone Number:

Thank you for referring to Total Senior Care!