 

 Referral for Services

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

|  |  |
| --- | --- |
| ***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 or[ ] Caregiver

***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!