## AGING AND DISABILITY RESOURCE CENTER OF BROWARD COUNTY (ADRC)

REFERRAL FORM for Funded Services. Please complete and fax to Helpline **(954) 745-9566.**

Referral Date: ____________________ Person Making This Referral: ______________________________________

Agency or Organization: ______________________________________________________________________________

Phone: ________________________ Fax: ______________________ E-mail: _____________________________

Original Referral Source (Self, Relative, Case Manager, etc.):______________________________ Phone#:__________________

**CONSUMER INFORMATION:**

Name: ____________________________________________________ Phone: _________________________

SSN: ________________________________ eCIRTS Client ID#: ______________________ Age:________

Address: ______________________________________________________ DOB: ________________________

City: __________________________________________ Zip Code: ____________________ ALF? _________

Primary Caregiver: Yes____ No____ Lives with CG: Yes____ No____ Live Alone: Yes____ No____

Caregiver Name: _____________________________________ Relationship: ___________________________

Caregiver Phone Number: _______________________________ Additional #: __________________________

Dementia Diagnosis: Yes_____ No_____

Individual Income: _________________ Couple's: _________________

Individual Assets: _________________ Couple's: _________________

Gender: Female______ Male:______ Unknown:_______

Race:______________________________________ Ethnicity:________________________________________

Facility Choice for Funded Adult Day Care: ________________________________________________________

Additional Data:

**FUNDED SERVICES REQUESTED:**

| Services Needed | Frequency | Units | Services Needed | Frequency | Units |
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