AGING AND DISABILITY RESOURCE CENTER OF BROWARD COUNTY (ADRC)

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

Referral Date: _____ Person Making This Referral: _____

Agency or Organization: _____ ☐ No Need to Reply/Update

Phone: _____ Fax: _____ E-mail: _____

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

CONSUMER INFORMATION: CIRTS Owner ID#: _____

Name: _____ Phone: _____

SSN: _____ CIRTS ID#: _____ Age:_____

Address: _____ DOB: _____

City: _____ Zip Code: _____ ALF? _____

Medicaid: Yes____ No____ If Yes: 10 Digit # _____ Program Code:_____

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

Caregiver Name: _____ Relationship: _____

Caregiver Phone Number: _____ Additional #: _____

Dementia Diagnosis: Yes___ No___ In CIRTS Date: 701A _____ 701B _____ 701S_____

Consumer is: ☐ Veteran ☐ Spouse of a Veteran ☐ Dependent of a Veteran

Individual Income: _____ Couple's: _____

Individual Assets: _____ Couple's: _____

Geographic Preference for **ADC**, **ALF** or **NH**: _____

Additional Data:

SCREENER INFORMATION:	Notes: Date :_____
Name:	
Agency:	
Phone :	
Fax:	

FUNDED SERVICES REQUESTED:

Services Needed	Frequency	Units	Services Needed	Frequency	Units

Referrals made by the ADRC to PSA 10 Projects as "APPL" are understood to have been option counseled, screened, and found likely to meet funded program eligibility requirements. It is the responsibility of the PSA 10 Project to complete all required assessment, care plan, and information verification activities to ensure that the referred client does in fact meet the funded program eligibility requirements.