Washoe County: Senior Services Referral Form

Fax to: (775) 325-8025 Phone: (775) 328-2575

***Required Info – PRINT CLEARLY &LEGIBLY**

***Last Name/First Name:** ***Date:**

***Address:** ***Apt.#:**

***City:** **State:** ***Zip:**

***Phone: (   )** Home Cell ☐ Other:

Alt. Phone: (   ) ☐ Home ☐ Cell ☐ Other:

***Date of Birth:** ***Social Security Number:**

***Gender:** ☐ Male ☐ Female ***Veteran Status:** ☐ Veteran ☐ Non-Veteran ☐ Spouse of Veteran

***Lives Alone:** ☐ Yes ☐ No ***Marital Status:** ☐ M ☐ S ☐ D ☐ W Other

*If No, lives with: ***SPOUSE NAME:** ***DOB:**

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Unknown

***Gross Monthly Income:** ____________ ***Source of income:**______________________________
(TOTAL household) (SS, SSI,401K,PENSION, VA, ETC.)

***Ambulation:** ☐ Walker ☐ Wheelchair Electric ☐ Wheelchair Manual ☐ Cane

*Task	Independent	Need Assistance	Unable to Perform
Bathing	☐	☐	☐
Toileting	☐	☐	☐
Eating	☐	☐	☐
Dressing	☐	☐	☐
Hygiene/Grooming	☐	☐	☐
Mobility	☐	☐	☐
Turns/Transfers	☐	☐	☐
	☐	☐	☐

*Task	Independent	Need Assistance	Unable to Perform
Shopping	☐	☐	☐
Cooking	☐	☐	☐
Housework/Laundry	☐	☐	☐
Medication Management	☐	☐	☐
Transportation	☐	☐	☐
Money Management	☐	☐	☐
Use Telephone	☐	☐	☐

***Reason for Referral (i.e.: Diagnosis/Health & Physical Conditions):**

***Support System:** ☐ Family ☐ Friend ☐ Neighbor ☐ Other

Name: Relationship: Phone #:

***SERVICE(S) BEING REQUESTED (☑ below)**

☐ INFO & REFERRAL ☐ HOME DEL. MEALS ☐ CASE MGMT ☐ HOMEMAKER ☐ REP PAYEE

☐ ADULT DAYCARE IS CLIENT ON HCBW (CHIP) W/ ADSD? ☐**YES** ☐ **NO** ☐ **PEN** ☐ **WAITLISTED**

CLIENT AWARE & RECEPTIVE TO REFERRAL/SERVICES: ☐**YES** ☐ **NO**

*REFERRED BY: *PHONE#:

FOR OFFICE USE ONLY:

☐ IN SYSTEM ☐ 2ND REFERRAL SW:____________________ DATE RECEIVED:______________

SERVICE: ☐ ACCEPTED ☐ REFUSED ☐ WAITLISTED ☐ INELIGIBLE ☐ REFERRED TO:____________
HDM STARTED: ☐ YES ☐ NO