Metrowest ADRC Information and Referral Form –for ADRC and LTCOC

Navigation Instructions
To navigate between fields, press only the tab key
Enter information by clicking on the shaded boxes

Information & Referral Date:

Information & Referral Worker:

Information & Referral Agency BayPath

Referral Source Name

RS Agency Name:

RS Title Discharge Planner

RS area code and phone number:

RS has permission to share info? Yes ☐ No ☐

Consumer Name:

Consumer's Current Address:

Facility Name if applicable:

Consumer's street and apt number:

Consumer's City, State and Zip

Consumer's area code and phone number

Is this a temporary address ☐ yes ☐ no

Expected duration at temporary address?

If yes, consumer's permanent address

Permanent Street Address:

Permanent City, State, Zip:

Permanent Area Code and Phone number:

Consumer date of birth (or age if d/o/b unknown)

Consumer gender M☐ F☐ Unk ☐

Consumer marital status S☐ M☐ W☐ D☐ Unk☐

Does consumer have a guardian? Yes ☐ No☐ Unk ☐

If so, Name of Guardian:

Guardian Street Address:

Guardian City State Zip:
Guardian Area Code and Phone:

Contact consumer directly Y☐ N☐

If no, alternate contact – first & last name

Alternate contact area code and phone number

Alt. contact relationship to consumer none

Is home wheelchair accessible? Y☐ N☐ Unk☐

Is consumer on MassHealth? Y☐ N☐ Unk☐

What is consumer's annual income?

Primary language spoken?

Does consumer have an interpreter? Yes☐ No☐ Unk☐

Interpreter's name

Interpreter's area code and phone number

Interpreter's relationship to consumer

Consumer Health Information and Disability Type (check all that apply)

- ☐ ALS
- ☐ ALZ or dementia
- ☐ Ambulation impairment
- ☐ Amputation
- ☐ Arthritis
- ☐ Blind/visual impairment
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ COPD
- ☐ Chemical dependency
- ☐ Deaf/hearing impairment
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Head Injury
- ☐ HIV/AIDS
- ☐ Mental Illness
- ☐ Mental Retardation
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's
- ☐ Speech impairment
- ☐ Spina Bifida
- ☐ Spinal Cord Injury
- ☐ Stroke

Other (please list)

From LIST ABOVE, please indicate PRIMARY DISABILITY:

Will this disability last more than 12 months? Yes☐ No☐ Unk☐

Type of Assistance or Information Requested (check all that apply)

- ☐ ADA
- ☐ Advocacy
- ☐ Housing
- ☐ Assistive Technology
- ☐ Bathing
- ☐ Cleaning
- ☐ PCA Services
- ☐ Peer Support
- ☐ Family Caregiver Support
- ☐ Community Transition Coordination at ILC
- ☐ Companion
- ☐ Day Program
- ☐ Dressing
- ☐ Employment/Vocational
- ☐ Financial Assistance
- ☐ Laundry
- ☐ Independent Living Skills training
- ☐ Long Term Care Options Counseling
- ☐ CSSM at ASAP
- ☐ Legal
- ☐ Money Management
- ☐ Respite
- ☐ Shopping
- ☐ Social/Recreational
- ☐ Transportation

Other

Additional Comments

Referral Tracking Information
Date form emailed

Form emailed to:ssalamoff@baypath.org
