



REFERRAL

Please email referrals to **<u>RCFreferral@ourhousenw.org</u>**

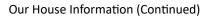
Referral So	ource						
Contact Name:							
Email:			Phone:			_ Fax:	
Client Con	tact Inform	ation					
Name:		Ca	ıll me:	Proi	nouns:		
		City:					
County:			D	ОВ:			
		Sex:			-		
Ethnicity/Race	:		Primary Lang	uage:			
Emergency Contact Name: Emergency contact Phone:							
			Emergency contact Phone:				
Screening	DHS services	DHS/ADS Screen:	: \Box applied date: _		🗆 approved o	date:	
ADS Screener	Name:		Phone:		Fax:		
Provider Ir	formation						
ID:		Organization:		Phone:		Fax:	
PCP: Organiz	zation:	PI	hone:	Fax:			
Other: Organiza	ation:	PI	hone:	Fax:			
*If there are addition	nal medical providers p	lease attach their contact i	nformation				
Nurse: Organiza	ation:	PI	hone:	Fax:	Social		
Worker:	Organization:	Phone:			Fax:		
DHS Worker:	Organization:		Phone:		Fax:		
Other Communit	ty Service Provide	ers (i.e.: Housing Case Agency:	Manager/Outread	h worker, Rep. Phone:	Payee/Money M	anager, POA, Guardian): Fax:	

Phone:

Fax:

CVID





Insurance Inform	nation	*Please attach copies of Insurance Cards (front/back)				
Medicaid	Plan Name	:	Policy Number:			
Medicare	Plan Name					
	□ A □ B	🗆 C 🗆 D				
🗆 Kaiser	Plan Name	:	Member Number:			
Care of Oregon - A	-	e of Oregon - Healthsha				
	Plan Name	:	Member Number:			
Income Informati	ion					
Income Source:		Monthly Amount:				
Income Source:		Monthly Amount:				
Client Details						
Current Living Arrangemen	ts: 🗆 home/apt.	□ nursing facility (SNIF/ALF	F/RCF)			
□ Has struggled with place	ement in Home and Co	ommunity Based Care (HCBC)				
Elopement/Wander Risk	(
	-]Transferring bed/chair □ Walking □ Eating Doing housework □ Doing laundry □ Transportation			
HIV/AIDS Dement Current Status:	-		ition 🛛 Mental Health 🗆 Substance Use 🗆 Other			

Our House

(Rev.8.2022)