



# REFERRAL FORM

Revised 12/09/2022

DATE

## CLIENT SERVICES

IS THE CLIENT AWARE OF THIS REFERRAL ☐ Yes ☐ No

☐ BENEFITS COUNSELING (Medicare)

☐ EMERGENCY RESPONSE SERVICE (ERS)

### HEALTH MAINTENANCE

☐ Hearing Aides

☐ INCOME SUPPORT (i.e. utility bill support)

☐ Dental Services

### NUTRITION SERVICES

☐ Congregate Meals

(Minor) RESIDENTIAL REPAIR/MODIFICATION

☐ Home-Delivered Meals

### HOMEMAKER

☐ OTHER REQUESTED SERVICES

### PERSONAL ASSISTANCE

### RESPIRE IN-HOME

If this a HOSPITAL DISCHARGE

Name of Facility \_\_\_\_\_

Date of Discharge \_\_\_\_\_

Service Definitions Available at: <https://www.easttexasaaa.org/services>

## CLIENT INFORMATION

LAST		FIRST		MI
ADDRESS			DOB	
CITY		ZIP	COUNTY	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	RACE <input type="checkbox"/> BL <input type="checkbox"/> WH <input type="checkbox"/> HSP <input type="checkbox"/> ASIAN <input type="checkbox"/> INDIAN		LANGUAGE	
PHONE NUMBER				

## CAREGIVER or EMERGENCY CONTACT INFORMATION

FULL NAME	RELATIONSHIP
PHONE NUMBER	

## REFERRED BY:

FULL NAME	AGENCY
PHONE NUMBER	FAX/EMAIL

## PLEASE EXPLAIN WHY THE CONSUMER NEEDS SERVICES

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All services are based on eligibility and contingent on available funds.

This form can be faxed to the Area Agency on Aging of East Texas at 903-984-4482.

[www.easttexasaaa.org](http://www.easttexasaaa.org)