Referral for Assistance
SOUTHERN ALABAMA REGIONAL COUNCIL ON AGING (SARCOA)
1075 S. Brannon Stand Rd. ~ Dothan, AL 36305 ~ Phone: 334-793-6843/ 1-800-239-3507 ~ Fax: 334-671-3651

Date: _____ Person Making Referral: _____ Agency/ Relation: _____

Last Name: _____ First: _____ M.I.: ____ DOB: _____ Age: _____ S.S. # _____ (Circle One) **Male Female**

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Other Phone: _____ Email: _____ Preferred Contact: Phone Mail Email

Race: (circle what apply) Caucasian African Am Alaskan Am Indian Hawaiian Pac Islander Other (specify) _____

Ethnicity: Hispanic/ Latino_____ Not Hispanic/ Latino _____ **Marital Status**: _____Single _____Married _____Separated _____Divorced _____Widowed

What is your preferred language? _____ Any special requirements due to your cultural and/or religious beliefs? ____YES ____NO

Are You a Veteran? ____YES ____NO **Spouse or Dependent of a Veteran?** ____YES ____NO **Have you applied for Veteran's Benefits?** ____YES ____NO

Do you have Medicare? ____ YES ____ NO **What Parts?** (circle what apply) A B D **Medicare #**: _____

Do you have Medicaid? ____ YES ____ NO **Medicaid #:** _____ **Do you receive?** QMB SLMB QI-1 SSI

Caregiver (unpaid): _____ **DOB:_____ Relation**: _____ **Phone#:** _____

Address: _____ City: _____ State: _____ Zip: _____ County: _____

Living Situation: _____Alone _____W/Spouse or Domestic Partner _____W/Parents _____W/Relative _____W/ Non-Relatives _____W/ Caregiver

How many people live with you, including yourself? _____ **Total Household Income (Gross): $_____** (Monthly)
Do you Drive? ___ YES ___ NO

SOURCES OF INCOME:

Salary/ Wages	**$**	Child Support	**$**	Social Security	**$**
Veteran's Benefits	**$**	Pension	**$**	Social Security Disability	**$**
Railroad Retirement	**$**	Interest Income	**$**	SSI	**$**
Unemployment	**$**	Other	**$**		

Primary Physician: _____ Address: _____ Phone: _____

Medical Condition: (check all that apply)

Alcoholism		Arthritis		Diabetes		Hearing Impaired		Mental Illness		Renal Failure	
Asthma		Cancer		Head Injury		HIV/ AIDS		Multiple Sclerosis		Stroke	
Alzheimer's/Dementia		COPD		Gastrointestinal		Hypertension		Paralysis		Visually Impaired	
Amputee		Depression		Heart Dz/ CHF		Incontinence		Parkinson's		Seizure	

Other Diagnoses: _____

How often do you see your doctor? _____

Special Diet? Y or N
What? _____

Do you exercise? Y or N

How often do you exercise? _____

Do You Have?

__ Home Modifications __ Ramps
__ Incontinent Supplies __ Shower Chair
__ Oxygen __ Walker
__ Lift __ Wheelchair

Current Services:

___ DHR
___ Home Health
___ Hospice

What outcome would you like from this referral?

Help With: (circle all that apply)

AESAP/ SNAP Legal Assistance
Alabama Cares Medicaid Waiver
Caregiver Services Personal Care
Energy Assistance Senior Center
Food Assistance SHIP Counseling
Homemaker Services Homebound Meals
Home Health Prescription Assistance
Other: _____

Need Help With?

__Walking __ Housework
__ Eating __ Preparing Meals
__ Dressing __ Toileting
__ Bathing __ Managing Money/ Meds

Have you been in last six months?

Hospital (Discharge Date_____)
Rehab (Discharge Date_____)
Nursing Home (Discharge date_____)

Do you currently receive services through SARCOA?

YES or NO

Which Program?

_____

Do you currently receive assistance through the Alabama Food Assistance Program (food stamps)? _____ YES _____ NO

Do you have a Power of Attorney? ___ YES ___ NO Are you in need of securing a Power of Attorney? ____ YES ____ NO

Do you have a Last Will/ Testament? ____ YES ____ NO Are you in need of securing a Last Will/ Testament? ____ YES ____ NO