R.A.I.N. Home Attendant Services, Inc.

811 Morris Park Avenue | Bronx, NY 10462 | 718.829.2131 | raininc.org

Serving the Community Since 1964

REFERRAL FORM

REFERRAL DATE: ________________

Last Name:________________________________**Middle Initial**: ____ **First Name**:________________________________

Address:____ **Apt #**:____________________

City:________________ **State**: _______ **Zip Code**:________________

Primary Language:_________________***Home Phone #:*** ____________________***Mobile Phone #***:____________________

Gender: Male Female **Date of Birth**:_______________ **Social Security #:**________________________

Emergency Contact______________________________**Relationship**________________**Phone #**:___________________

Medicaid #:_________________**Medicare #:**_________________ **Other Insurance**:________________________________

If Client doesn't have Medicaid, do they want to apply? **Yes** **No**

Client's Medical Provider:______________________________________ **Tel. Number:**___________________________

Was Client informed of referral? Yes No **Best time to call Client:** ____________________________

Does Client Currently Receive Service from Another Home Care Agency? **Yes** **No**

If Yes, Name of Agency:__________________________________ ***Hours Receiving***: ________ Hours ________ Days

REASON FOR REFERRAL:

Home Care Medicaid Assistance Transportation Meals on Wheels Other

Please list any medical problems the client is experiencing:

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Is there anything else we should know about the client's home care needs?

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REFERRAL SOURCE INFORMATION

Name and Title:————————————————————————*Organization:*————————————

Tel #:——————————————*Fax #:*——————————————*Email:*——————————————

Address: ____ *City:* __________ *State:* _______ *Zip Code:* _______________

Physician Signature: ____ *NPI #*___________________ *Date:* / /

Instructions: FAX to 718-409-3970 - Attention: Authorization/Referral Department – or call 718-829-2131 Ext. 129

Rev. August 2024