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**: NY **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:

_____

_____

_____

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

_____

_____

_____

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: Intake/Referral Department – or call 718-829-2131 Ext. 186

confirm receipt of fax

Rev. August 2024