

# HRDC Adult Day Care Services

Provider & Support Planner Referral Form · Allegany County, Maryland

Complete all fields and email or fax to: [tlawson-guthrie@alleganyhrdc.org](mailto:tlawson-guthrie@alleganyhrdc.org) | Fax: 301-777-8422 | Ph: 301-783-1810

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## SECTION 1 — REFERRING PROVIDER / SUPPORT PLANNER

Provider / Planner Name \*  Organization / Practice  Role / Title  Date of Referral \*  Best Contact Method

Phone \*  Fax  Email \*

## SECTION 2 — CLIENT INFORMATION

Client Full Name \*  Date of Birth \*  Gender  Phone  Medicaid ID

Home Address \*  City  State  Zip  County

Primary Caregiver / Emergency Contact \*  Relationship  Caregiver Phone \*  Caregiver Email

## SECTION 3 — INSURANCE & FUNDING SOURCE

Funding Source (check all that apply):

- Medicaid – Community First Choice       Medicaid – Community Options Waiver       Medicaid – REM Waiver  
 Medicare       Long-Term Care Insurance       Private Pay / Self-Pay

Insurance Name  Member / Policy ID  Group #  Auth / Case # (if known)

## SECTION 4 — DIAGNOSES & CONDITIONS

Primary Diagnosis \*  ICD-10 Code  Secondary Diagnoses

Relevant Conditions (check all that apply):

- Alzheimer's / Dementia       Parkinson's Disease       Stroke / TBI       Congestive Heart Failure  
 COPD / Respiratory       Diabetes       Intellectual / Dev. Disability       Depression / Anxiety  
 Fall Risk       Wound Care Needs       Chronic Pain       Other (see notes)

## SECTION 5 — FUNCTIONAL STATUS & CARE NEEDS

Assistance Needed (check all that apply):

- Bathing / Grooming       Dressing       Toileting       Ambulation / Transfers  
 Medication Management       Meal Preparation       Cognitive Supervision       Behavioral Monitoring  
 Physical Therapy       Occupational Therapy       Speech Therapy       Skilled Nursing

Mobility Status  Cognitive Level  Transportation Needed?  Falls in Past 6 Months

## SECTION 6 — REASON FOR REFERRAL & CLINICAL NOTES

Reason for Referral / Goals of Care \*

Current Medications, Allergies & Precautions

Preferred Start Date  Days / Hours Needed  Currently on Medicaid Waiver?  Waiver Type (if known)

## SECTION 7 — AUTHORIZATION & SIGNATURE

*By signing below I authorize release of relevant clinical information for the purpose of coordinating adult day care services for the individual named above.*

Provider Signature (type full name) \*  Title / Credentials  Date \*  NPI (if applicable)

\* Required fields. This form is transmitted in compliance with HIPAA. Information is used solely for care coordination purposes.