

### COMMUNITY REFERRAL FORM

**Identifying Information**

Patient Name \_\_\_\_\_ HH FCM referral:  Yes  No  
 Date of birth \_\_\_\_\_ Sex  M  F DNR  Yes  No  
 Social Security # \_\_\_\_\_ Health Care Proxy  Yes  No  Copy Attached  
 Home Address \_\_\_\_\_ Name \_\_\_\_\_  
 Telephone \_\_\_\_\_ Power of Attorney  Yes  No  Copy Attached  
 Military Service  Yes  No Service Connected  Yes  No Name: \_\_\_\_\_  
 Service Connection Percentage \_\_\_\_\_

**Contacts:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell \_\_\_\_\_  
 Address \_\_\_\_\_ Home \_\_\_\_\_  
 Work \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell \_\_\_\_\_  
 Address \_\_\_\_\_ Home \_\_\_\_\_  
 Work \_\_\_\_\_

**Insurance Information (include Policy Numbers and Telephone Numbers for No-fault & Commercial Insurances)**

<p><b>1) Insurance</b> _____</p> <p>Policy # _____</p> <p>Phone _____</p> <p><b>2) Insurance</b> _____</p> <p>Policy # _____</p> <p>Phone _____</p>	<p><b>3) Insurance</b> _____</p> <p>Policy # _____</p> <p>Phone _____</p> <p><input type="checkbox"/> Life Insurance Policy</p> <p>Policy # _____ Phone # _____</p> <p>Amount \$ _____</p> <p><input type="checkbox"/> Long Term Care Insurance</p> <p>Policy # _____ Phone # _____</p> <p>Amount \$ _____</p>
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**Financial Information (required to process application)**

Patient who is:  Single  Married  Separated  Divorced  Widowed

	<u>Patient</u>	<u>Spouse</u>
a) Total Monthly Income (salary, Pension, SSI, etc...)	specify amount \$ _____	specify amount \$ _____
b) Total Banking (Savings/Checking)	specify amount \$ _____	specify amount \$ _____
c) Stocks/Bonds	specify amount \$ _____	specify amount \$ _____
d) CD's	specify amount \$ _____	specify amount \$ _____
e) 401K, 403B	specify amount \$ _____	specify amount \$ _____
f) IRA	specify amount \$ _____	specify amount \$ _____

Trust Accounts  Yes  No  
 Amount: \_\_\_\_\_ Type of trust \_\_\_\_\_

**House:**  Yes  No **Spouse or Disabled Adult Child or Child under 21 years old in Home:**  Yes  No

**Other Real Estate/Rental Property**  Yes  No If yes, address \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Financial Advisor Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Has there been any transfer of funds/property within the last 60 months?**  Yes  No

If yes, state amount and reason for transfer: \_\_\_\_\_

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_