COMMUNITY REFERRAL FORM

Strong Memorial Hospital
Social Work Division

Identifying Information

Patient Name ______________________ Date of birth ______________
Home Address ______________________ Social Security # ______________
______________________ Sex ☐ M ☐ F
Telephone ______________________ Religion ______________
Military Service ☐ Yes ☐ No Service Connected ☐ Yes ☐ No Admission date______________
Service Connection Percentage ______________ DNR ☐ Yes ☐ No
Attending MD ______________________ Health Care Proxy ☐ Yes ☐ No ☐ Copy Attached
Family MD ______________________ Name ______________

Contacts:

Name ______________Relationship__________ Phone: Cell ______________
Address ______________________ Home ______________
☐ Power of Attorney ☐ Copy Attached Work ______________
Name ______________Relationship__________ Phone: Cell ______________
Address ______________________ Home ______________
☐ Power of Attorney ☐ Copy Attached Work ______________

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

Medicare: ______________ ☐A ☐B Commercial/HMO Plan__________Policy #__________

Medicare D Plan:______________ SNF Benefit______________

Medicaid CIN: __________ Spend down ☐ ________ Workers' Comp: ______________

Medicaid HMO: ______________ Policy #__________Phone:__________

MA Financial CM Referral Date: ______________ No Fault/MVA: ______________

MA Applic. Date:________DSS Date__________ Policy #__________ Phone:__________

Financial Case Manager: ______________

Financial Information (required to process application)

Patient who is: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed

	Patient	*Spouse*
a) Monthly Income	specify amount $ __________ ☐ Salary ☐ Pension ☐ Other ☐ Social Security	specify amount $__________ ☐ Salary ☐ Pension ☐ Other ☐ Social Security
b) Bank Accounts	specify amount $ __________	specify amount $ __________
c) Stocks	specify amount $ __________	specify amount $ __________
d) CD's	specify amount $ __________	specify amount $ __________
e) Trust Account ☐ Yes ☐ No	specify amount $ __________	specify amount $ __________
f) IRA, 401, 403B	specify amount $ __________	specify amount $ __________

House: ☐ Yes ☐ No Other Real Estate/Rental Property ☐ Yes ☐ No If yes, address______________
Spouse or Disabled Adult Child or Child under 21 years old in Home: ☐ Yes ☐ No
Attorney ☐ 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:

Social Worker Initials: Date: