

AGING AND DISABILITY RESOURCE CENTER OF BROWARD COUNTY (ADRC)
REFERRAL FORM for Funded Services. Please complete and fax to (954) 745-9566.

Referral Date: _____ Person Making This Referral: _____
 Agency or Organization: _____ No Need to Reply/Update
 Phone: _____ Fax: _____ E-mail: _____
 Original Referral Source (Self, Relative, Case Manager, etc.): _____ Phone#: _____

CONSUMER INFORMATION:

CIRTS Owner ID#: _____
 Name: _____ Phone: _____
 SSN: _____ CIRTS ID#: _____ Age: _____
 Address: _____ DOB: _____
 City: _____ Zip Code: _____ ALF? _____
 Medicaid: Yes ___ No ___ If Yes: 10 Digit # _____ Program Code: _____
 Primary Caregiver: Yes ___ No ___ Lives with CG: Yes ___ No ___ Live Alone: Yes ___ No ___
 Caregiver Name: _____ Relationship: _____
 Caregiver Phone Number: _____ Additional #: _____
 Dementia Diagnosis: Yes ___ No ___ In CIRTS Date: 701A _____ 701B _____ 701S _____
 Consumer is: Veteran Spouse of a Veteran Dependent of a Veteran
 Individual Income: _____ Couple's: _____
 Individual Assets: _____ Couple's: _____
 Geographic Preference for **ADC**, **ALF** or **NH**: _____
 Additional Data:

SCREENER INFORMATION:

Notes:	Date : _____
Name:	_____
Agency:	_____
Phone :	_____
Fax:	_____

FUNDED SERVICES REQUESTED:

Services Needed	Frequency	Units	Services Needed	Frequency	Units

Referrals made by the ADRC to PSA 10 Projects as "APPL" are understood to have been option counseled, screened, and found likely to meet funded program eligibility requirements. It is the responsibility of the PSA 10 Project to complete all required assessment, care plan, and information verification activities to ensure that the referred client does in fact meet the funded program eligibility requirements.