STATE PLAN HOME HEALTH SERVICES HEALTHCHEK REFERRAL FORM

DATE: ______________________________

CONSUMER NAME: __________________________________ **PHONE:** ________________

STREET ADDRESS: ____

CITY / ZIP: _________________________________ **COUNTY:** _____________________

DATE OF BIRTH: ___________________ **SOCIAL SECURITY #** ______________________

DIAGNOSIS: ____

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REFERRAL made by: ____

NAME: ________________________________ **PHONE:** ______________________

Provider Home Health Agency: ____

PHONE: ______________________________ **FAX:** ______________________________

Does the consumer have Medicaid? (If HMO, cannot do HealthChek)

If "YES", Billing #	If "NO": refer to apply for Medicaid or use private insurance

Are they under 21?

If "YES", What services are they seeking?	If "NO", Did consumer have a 3-day hospital stay?
☐ Home Health Aide ☐ Skilled Nursing (Up to 4 hours/day) ☐ Private Duty Nursing (More than 4 hours/day? ****Please refer to State Plan PDN	If "YES" Refer to agency for State Plan Increased Home Health Services. If "NO" Refer to agency for State Plan Home Health Services.

To complete assessment , please contact:

Name: ___________________________________ **Relation to Consumer:** _________________

Phone: ______________________________ **Alternate Phone:** ______________________