ACCORD

Bringing Possibilities to Life

HOME HEALTH ADMISSION INQUIRY (PRE-REFERRAL) FORM

For questions, please call the Home Health line at 612-455-1236 or email homehealthreferrals@accord.org. Fax this completed form to: **1.612.547.0556** (Must use 1 first) or send via secure email to: homehealthreferrals@accord.org.	**Date:**
Individual's Last Name: **First Name:** **Middle Initial:**	
Address: Zip:	
Phone: Email:	
Date of Birth:	**Social Security #:**
Preferred Language:	**Interpreter Needed:** ☐ Yes ☐ No
Representative/Emergency Contact Name:	
Address: State: Zip:	
Phone #: Email: Relationship:	
☐ Legal Guardian ☐ Power of Attorney (If yes, request to send documenation)	
Location of Person: ☐ Community ☐ Health Care Facility Name:_____ Dates of Stay:	
Referred By: **Organization:**	
Phone: Email:	
☐ Self/Family ☐ Clinic Specify: ☐ Health Care Facility Discharge Planner ☐ WA County Behavioral Health Case Manager	☐ Other/specify: ☐ Waiver/AC Case Manager/Care Coordinator ☐ MCO Care Coordinator
Services Request & Frequency: ☐ SNV:_____ ☐ PT:_____ OT:_____ ☐ ST:_____ ☐ Home Health Aide:_____ Comments:	
Reason for Referral (Mark all that apply): ☐ Cognitive Issues/Support ☐ Disease Management/Education ☐ Falls Prevention Management ☐Family Caregiver Education/Support ☐Infection Mgmt/Monitoring ☐ INR/Blood Draw ☐ Medication Management ☐ Medication Non-Compliance ☐ Mental Health Illness Monitoring/Support ☐ Nursing Assessment/Clinical Monitoring ☐ Orthopedic Care ☐ Ostomy Education ☐ Personal Cares ☐ Poor coping mechanisms ☐ Post-Surgical ☐ Rehabilitation Therapy ☐ Safety Issues ☐ Uriniary Catheter Management ☐ Wound Care Special Treatments: _____Next Injection Due: _____	

ACCORD

Bringing Possibilities to Life

☐ Currently or within past 60 days person was receiving home health care? ☐ Yes ☐ No Specify Agency Name: Phone: Other home and community-based service agencies involved:			
Diagnos(es):			
Primary Health Care Provider Name: **Clinic Name:**			
Address:	City:	Zip:	
Phone #:	Fax#:	Email:	
Secondary Health Care Provider Name: **Clinic Name:**			
Address:	City:	Zip:	
Phone #:	Fax #:	Email:	

PAYMENT INFORMATION

☐ Self-pay	☐ Veterans Health Administration	☐ Washington County Grant	☐ Other

☐ Private Insurance/Health Plan Name:_____ Product Name:_____
ID Number:_____ Group #:_____
Type:_____ Policy Holder Name:_____

☐ Medicare Original/Number:_____
☐ Medicare Supplemental/Health Plan Name: _____ ID#:_____
☐ Medicare Advantage/Health Plan Name:_____ ID#:_____

☐ Medical Assistance/ PMI #:_____
☐ Medical Assistance Under Managed Care/Health Plan Name:_____
☐ Medical Assistance HCBS Waiver: ☐ Alternative Care Program ☐ CAC ☐ CADI ☐ DD ☐ Elderly Waiver ☐ TBI

Payor Coverage Verified ☐ **Yes** ☐ **No** DATE: _____ Initials:_____

Accord Staff Completing Form: ☐ Sent to Intake Staff Date:_____

Comments: