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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:**
Address:	City:	Zip:
Phone:	Email:	
Date of Birth:	**Social Security #:**	
Race/Ethnicity:	**Preferred Language:**	**Interpreter Needed:** ☐ Yes ☐ No
Representative/Emergency Contact Name:		
☐ Legal Guardian ☐ Power of Attorney (If yes, request to send documentation)		
Address:	City:	Zip:
Phone #:	Email:	Relationship:
Location of Person: ☐ Community ☐ Health Care Facility Name:_____ Dates of Stay:		
Referred By:	**Organization:**	
Phone:	Fax:	Email:
☐ Self/Family ☐ ☐ Clinic Specify: ☐ Health Care Facility Discharge Planner ☐ Behavioral Health Case Manager	☐ Waiver/AC Case Manager ☐ Care Coordinator ☐ Managed Care Coordinator ☐ Other/specify:	

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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 ☐ Urinary Catheter Management ☐ Wound Care

Special Treatments: _____Next Injection Due: _____

☐ 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:
☐ Medical Provider ☐ Psychiatric Provider

Address:	City:	Zip:
Phone #:	Fax#:	Email:

Secondary Health Care Provider Name:
Clinic Name:
☐ Medical Provider ☐ Psychiatric Provider

Address:	City:	Zip:
Phone #:	Fax #:	Email:

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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

Comments:

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

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