DELAWARE COUNTY OFFICE OF SERVICES FOR THE AGING

Pre-admission Referral Cover Sheet

CONSUMER INFORMATION

Name: ____

(Last) (First) (Middle Initial)

Home Address: ____

(Town) (Zip)

Phone: ________________________ Social Security: ____________________________________

Sex:______________ DOB:____________ Language:____________________ Marital Status: ________

MA# ____________________________

CONTACT INFORMATION (family/interested party)

Name:____ Relationship: ____________________________________

Address: ____

Phone(home):_______________________(Work)_____________________(Cell)______________________________

Email Address:____

PROFESSIONAL CONTACT (referral person)

Name: ____ Phone: ________________________________

Facility: ____Rm#:____________________________________

Building (If applicable):_ _____________________________________Admission Date: _________________________

Comment:____

REFERRING PHYSICIAN

Name: ____ Phone________________________________

Address:____

REASON FOR REFERRAL (Check One)

___access MA nursing home payment (include MA51, PASRR)

___OBRA…private and for MA payment (include MA51, PASRR, supporting documents)

___Boarding/dom care home…new or recert (include MA51, additional documents)

Pre-admission referrals should be faxed to (610) 499-1826 or mailed attn: PAA Unit