NHCP NEIGHBORHOOD HOUSING + CARE PROGRAM

CAP

REFERRAL INFORMATION

Program: ☐ **NHCP**

****Please fax completed referral sheet to 503-239-5062**

Referral Source

Contact Name: _____ Organization (if applicable): _____

Email: _____ Phone: _____ Fax: _____

Client Contact Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ DOB: _____ SS#: _____ Gender: _____

Ethnicity/Race: _____ Primary Language: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Provider Information

ID: _____ Organization: _____ Phone: _____ Fax: _____

PCP: _____ Organization: _____ Phone: _____ Fax: _____

Other: _____ Organization: _____ Phone: _____ Fax: _____

*If there are additional medical providers please attach their contact information

Nurse: _____ Organization: _____ Phone: _____ Fax: _____

Social Worker: _____ Organization: _____ Phone: _____ Fax: _____

DHS Worker: _____ Organization: _____ Phone: _____ Fax: _____

Other Community Service Providers (i.e.: Housing Case Manager/Outreach worker, Rep. Payee/Money Manager, POA, Guardian):

Name: _____ Agency: _____ Phone: _____ Fax: _____

Name: _____ Agency: _____ Phone: _____ Fax: _____

Insurance Information

***Please attach copies of Insurance Cards (front/back)**

☐ Medicaid Plan Name: _____ Policy Number: _____

☐ Medicare Plan Name: _____ Policy Number: _____

☐ A ☐ B ☐ C ☐ D

☐ Kaiser Plan Name: _____ Member Number: _____

☐ Care of Oregon - Advantage or ☐ Care of Oregon - Healthshare

Plan Name: _____ Member Number: _____

Income Information

Income Source: _____ Monthly Amount: _____

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Client Details

Current Living Arrangements: ☐ home/apt. ☐ nursing facility (SNIF/ALF/RCF) ☐ SRO ☐ houseless ☐ other

Care Needs: ☐ Bathing ☐ Dressing ☐ Grooming ☐ Oral care ☐ Toileting ☐ Transferring bed/chair ☐ Walking ☐ Eating ☐ Managing medications ☐ Using the phone and looking up numbers ☐ Doing housework ☐ Doing laundry ☐ Transportation ☐ Managing finances

☐ HIV/AIDS ☐ Dementia/Cognitive Function ☐ Unstable Medical Condition ☐ Mental Health ☐ Substance Use ☐ Other

Current Status: _____

Additional Notes: _____