AREA FIVE AGENCY REFERRAL FOR IN-HOME SERVICES
1801 Smith Street, Logansport, IN 46947
1-800-654-9421, 574-722-4451, 574-737-2100
Please fax to (574) 722-3447, ATTN: ADRC

First Name		**Middle**		**Last Name**					
Address									
Phone		**Medicaid status**		**Gender**		**Race/ Ethnicity**			
SSN		**DOB**		**Veteran/ Spouse of**	Y / N	**Marital status**	M / S / D / W		
# in household		**Income $ Monthly**				**Currently in nursing facility?**	Y / N		
In Nursing Facility, how long?(days)		**Name of Facility**							

Emergency Contacts

Name	**Relationship**	**Date of Birth**	**Phone Number**
1.			
2.			
3.			

Primary Care Physician Name, address and phone number

Primary Care Physician Name, address and phone number	
Describe the assistance needed by patient	
Medical Conditions/ Diagnoses	
Support Systems (formal & informal) and any assistance currently provided	
Referral Source (Name of person, entity, organization, etc and contact)	

AREA FIVE AGENCY WILL USE THE INFORMATION ON THIS REFERRAL TO CONTACT CLIENTS, EXPLAIN SERVICES OFFERED AND ARRANGE FOR CLIENTS TO BE SCREENED FOR POSSIBLE SERVICES.