

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: _____

CONTACT INFORMATION (family/interested party)

Name: _____ Relationship: _____

Address: _____

Phone(home): _____ (Work) _____ (Cell) _____

Email Address: _____

PROFESSIONAL CONTACT (referral person)

Name: _____ Phone: _____

Facility: _____ Admission Date: _____

REFERRING PHYSICIAN

Name: _____ Phone _____

Address: _____

INSURANCE

Medicare # _____ MA# _____

Other: _____

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)
- Life at home

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