



**CAREGIVER™**  
**HOMES**  
*of Massachusetts*

20 Park Plaza, Suite 920  
 Boston, MA 02116  
 www.caregiverhomes.com

**Referral Form**  
 Fax toll free to: (866)-646-1543  
 Telephone: (866)-797-2333

**Date of Referral:** \_\_\_\_\_ **Referral Info: Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 Agency (if applicable): \_\_\_\_\_

**Name of Client:** \_\_\_\_\_ **Client Phone:** \_\_\_\_\_  
 Client Address: \_\_\_\_\_

**Primary Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
 Primary Contact Address: \_\_\_\_\_

**Relationship to Participant:** \_\_\_\_\_ **Applying to be caregiver? [Y N]**

**Legal Guardian Name (if applicable):** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Demographic Information:**

Current Living Situation:  Private Home/Apt  Lives with Family  Shared Living/Group Home  
 Assisted Living Facility  Skilled Nursing Facility  Other Housing (specify): \_\_\_\_\_

**Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:**  M  F **Marital Status:**  M  W  D  S

**Race:** \_\_\_\_\_ **Religion:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_

**Health Insurance (√ all that apply):**  Medicare  Medicaid  VA/Champus  Other \_\_\_\_\_

**Mass Health ID #:** \_\_\_\_\_ **Soc Sec #:** \_\_\_\_\_

**Income (monthly):** SS: \_\_\_\_\_ SSI: \_\_\_\_\_ SSDI: \_\_\_\_\_ Pension: \_\_\_\_\_ Other: \_\_\_\_\_ Total: \_\_\_\_\_

**Current Service Package (please specify agency/hours on space listed below):**

VA  MRC  VNA (specify): \_\_\_\_\_  PACE: \_\_\_\_\_  SCO: \_\_\_\_\_  
 ASAP (services): \_\_\_\_\_  PCA: \_\_\_\_\_  ADH: \_\_\_\_\_  DMR  DMH  SHIP

**Agency Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical/Behavioral History:**

**ADLs :** Circle for level of assistance required [C/S= cueing/supervision, A = Assist, D = Dependent]

Bathing [ C/S A D ] Toileting [ C/S A D ] Dressing [ C/S A D ] Ambulation [ C/S A D ]  
 Transfers [ C/S A D ] Med Mgmt [ C/S A D ] Eating [ C/S A D ] Personal Hygiene [ C/S A D ]

**Special Considerations:** Circle for each [Y = Yes, N = No]

Wheelchair [ Y N ] Walker/Cane [ Y N ] Difficulty with Stairs [ Y N ] Oxygen [ Y N ] Behaviors [ Y N ]  
 Safety [ Y N ] Smoker [ Y N ] Alcohol use [ Y N ] Special Diet [ Y N ] Incontinence [ Y N ]

Is client able to be left alone for short periods of time? [Y N] If yes, how long?