Elderly and Disabled Waiver Program Referral Form

St. Joseph's/Candler
Georgia Infirmary

1900 Abercorn Street • Savannah, Georgia 31401
Please submit referrals to gaireferrals@sjchs.org
For questions, call (912) 819-1530 • Fax: (912) 819-1548

Referral Date ____/____/____ Referred by _____

Contact Name _____ Contact Phone /Email _____

Referral Notes _____

APPLICANT INFORMATION

Name _____ DOB ____/____/____ SSN _____

Sex ○ Male ○ Female Marital Status ○ Married ○ Widow ○ Single ○ Divorced Veteran ○ Yes ○ No

Medicare # _____ Medicaid # _____

Applicant receives SSI? ○ Yes ○ No Monthly Income _____

Living Arrangement ○ Alone ○ With Spouse ○ With Family/Friends ○ Nursing Home ○ Personal Care Home

Physical Address _____

City _____ County _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Primary Caregiver _____ Relationship to Applicant _____

Primary Care Physician _____ Date of Last Visit ____/____/____

Diagnoses _____

○ Deaf/Hard of Hearinc ○ Blind ○ Low Vision ○ Dementia ○ Aphasia ○ Limited English

Information Requested _____

Services Requested ○ Personal Care/Support ○ Light Housekeeping/Shopping/Errands/Meal Prep ○ Home Delivered Meals
○ Emergency Response System ○ Adult Day Care ○ Personal Care Home

Services Currently Provided _____

APPLICANT'S PRIMARY CONTACT (please send all information to this individual)

Name _____ Relationship to Applicant _____

Physical Address _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

SJ/C USE ONLY

Initial Caller _____ Screen Date ____/____/____

Referred for Assessment? ○ Yes ○ No If yes, which program? ○ SOURCE ○ CCSP Referred Date ____/____/____

Willing to use SRC PCP? ○ Yes ○ No ○ N/A Referred to other services ○ Yes ○ No Other _____

Ineligible Reason _____

Co-worker name _____ Signature _____