REFERRAL & ELIGIBILITY FORM

ADULT DAY PROGRAMS

Fax this form to HNHB CCAC 1-866-655-6402

Above area is intentionally left blank for CCAC stamp

SECTION 1: To be completed by Referral Source

U ˚ hO ˙o :

Patient Name: Date of Birth(dd/mm/yyyy):

HCN: Phone #:

Address: City: ***P***ostal Code:

Contact Person: Relationship:

Phone # (Home): (Work):

Consent to Share Information with all selected adult day provider(s) and CCACs:

Consent provided by:

Date of last RAI-HC/RAI-CA or RAI-CHA: (dd/mm/yyyy) Not Known ☐OR See attached ☐

Patient communicates in English: Preferred language:

Transportation

Patient will need to access transportation services for program:

Patient will have own transportation services for program:

Details (if known):

Additional Information:

Completed by: Date (dd/mm/yyyy):

Referring Agency: Phone #: _

SECTION 2: To be completed by CCAC only

Patient is currently on CCAC long-stay services (i.e. not acute):

Determination of Eligibility for Adult Day Service **Applicant must meet all criteria:**

Applicant is 18 years of age or over ☐ Applicant has a valid health card number ☐

Applicant does not pose a risk to self or others ☐

Priority: Applicant meets the following criteria and has been discussed with a Client Services manager who has confirmed appropriateness for increased priority ☐

1) ALC senior waiting for discharge from hospital and adult day program is an integral part of the discharge plan **OR**
2) Is a senior in the community who may be in imminent need of a higher level of care than can be provided by CCAC regular services and who would otherwise be at high risk of hospitalization or admission to a LTCH.

Completed by: Ext: Date (dd/mm/yyyy):

CCAC fax this form to requested Adult Day Programs