GAFC Referral Form

Date of Referral: ______________________________

For PRS Care Manager Making Initial Referral:
☐ Check here if you do not want PRS marketing to contact this referral and you are handling all communication with this referral.

For Marketing: ☐ Check here if this is a call-in referral and you have not met the referral in person.

RELEASE OF INFORMATION

I, ______________________________ give permission to provide PRS with the information requested below for the purpose of determining if MassHealth/SCO/OC approves me as eligible to receive PRS Home Care Program for personal care and homemaking services in my home.

Signature: ______________________ Date: ______________

REFERRAL INFORMATION

Name: ______________________________ Primary Language: ______________

Site/Building Name: ______________________________

Street Address: ______________________________ City/State/Zip: ______________

Date of Birth: ______________ Gender Identification: Male ☐ Female ☐ Other: ☐ ______________

Primary Care Physician's Name: ______________________________ Telephone: ______________

Primary Care Physician's Address: ______________________________

Date of Last Primary Care Appointment: ______________________________

Referred By: ______________________________ ☐ PRS or Agency: ______________

Agency Address: ______________________________ Telephone #: ______________

Additional Comments:

____

Outcome of Referral:

____

Referral Admitted for PRS GAFC: ☐ Yes ☐ No If no, referral sent to: ______________________________

Please fax all referrals to Vinda Butler at 781.794.1087 or 781.796.1193 or email: bbutler@peabodyproperties.com