PACE OF THE SOUTHERN PIEDMONT

Referral Form

Mission

To be a leading not-for-profit provider and employer of choice offering comprehensive care services to enhance the life and autonomy of older adults.

REFERRAL CRITERIA

To receive PACE services, an individual must (*please check all that apply*)…

- O Be 55 years of age or older
- O Be determined to need nursing home level of care
- O Be able to live in a community setting when enrolled without jeopardizing health or safety
- O Reside in the PACE organization's service area (*Mecklenburg, Cabarrus, Union or Stanly Counties*)

REFERRAL INFORMATION

Last Name: _____ **First Name**: _____

Address: (*Street*) _____ **Age**: _____ **DOB**: _____

(*City/Zip*)_____ **Gender**: Male or Female

Insurance: (*circle one*) Medicare Medicaid Medicare/Medicaid Private Unknown

Family or Caregiver Name/Relationship: _____

Family or Caregiver phone number: **(***home*) _____ (*cell*) _____

REFERRAL SOURCE

Name and/or Organization: _____

Contact number: (*home/office*)_____ (*cell*) _____

Email Address: _____ **Fax**: _____

PLEASE FAX COMPLETED FORM AND ANY SUPPORTIVE MEDICAL DOCUMENTATION, IF AVAILABLE, TO 704-887-3844 ATTN: ENROLLMENT

Should you have any questions or need additional assistance please call us directly @ 704-887-3854