In-Home Counseling

Date *mm/dd/yyyy*:

Counseling Services Referral

Complete and RETURN TO: Counseling@familyeldercare.org

Referral Source:
Address: **City:** **Zip:**
Contact Person: **Phone:** **Email:**

Client Full Name: **DOB** *mm/dd/yyyy*:
Address: **City:** **Zip:**
Home Phone: **Cell Phone:**
Is client homebound? ☐ Yes ☐ No – *Client must be homebound for referral*
Is client aware of referral? ☐ Yes ☐ No – *Client must be willing to participate for services to begin*

Insurance Information: Medicare #: **Part B:** ☐ Yes ☐ No
Medicare Advantage Plan: ☐ No ☐ Yes **Plan Type / ID#:**
Supplemental Plan: ☐ No ☐ Yes – *Complete information below*
Plan Name: **ID#:**
Plan Phone:

How did you hear about Family Eldercare's Counseling Services?

Reason for referral:

Previous Mental Health Treatment:

List Medications:

Physician: **Phone:**

THANK YOU FOR YOUR REFERRAL TO FAMILY ELDERCARE