



REFERRAL INFORMATION

Program: Our House NHCP

****Please fax completed referral sheet to
503-239-5062**

Referral Source

Contact Name: _____ Organization (if applicable): _____

Email: _____ Phone: _____ Fax: _____

Client Contact Information

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ DOB: _____ SS#: _____ Gender: _____

Ethnicity/Race: _____ Primary Language: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Provider Information

ID: _____ Organization: _____ Phone: _____ Fax: _____

PCP: _____ Organization: _____ Phone: _____ Fax: _____

Other: _____ Organization: _____ Phone: _____ Fax: _____

*If there are additional medical providers please attach their contact information

Nurse: _____ Organization: _____ Phone: _____ Fax: _____

Social Worker: _____ Organization: _____ Phone: _____ Fax: _____

DHS Worker: _____ Organization: _____ Phone: _____ Fax: _____

Other Community Service Providers (i.e.: Housing Case Manager/Outreach worker, Rep. Payee/Money Manager, POA, Guardian):

Name: _____ Agency: _____ Phone: _____ Fax: _____

Name: _____ Agency: _____ Phone: _____ Fax: _____

Name: _____ Agency: _____ Phone: _____ Fax: _____

Insurance Information

***Please attach copies of Insurance Cards (front/back)**

Medicaid Plan Name: _____ Policy Number: _____

Medicare Plan Name: _____ Policy Number: _____

A B C D

Kaiser Plan Name: _____ Member Number: _____

Care of Oregon - Advantage or Care of Oregon - Healthshare

 Plan Name: _____ Member Number: _____

Our House ONLY

Is eligible for DHS services DHS/ADS Screen: applied date: _____ approved date: _____

ADS Screener Name: _____ Phone: _____ Fax: _____

Income Information

Income Source: _____ Monthly Amount: _____

Income Source: _____ Monthly Amount: _____

Client Details

Current Living Arrangements: home/apt. nursing facility (SNIF/ALF/RCF) SRO houseless other

Has struggled with placement in Home and Community Based Care (HCBC)

Elopement/Wander Risk

Care Needs: Bathing Dressing Grooming Oral care Toileting Transferring bed/chair Walking Eating

Managing medications Using the phone and looking up numbers Doing housework Doing laundry Transportation

Managing finances

HIV/AIDS Dementia/Cognitive Function Unstable Medical Condition Mental Health Substance Use Other

Current Status: _____

Additional Notes: _____