In-Home Counseling

Counseling Services Referral

Complete and RETURN TO: Counseling@familyeldercare.org

Date:

Referral Agency/Clinic:	**Phone:**
Contact Person:	**Email:**

Client Legal Name: **Preferred Name:** **DOB:**

Address: **City:** **Zip:**

Home Phone: **Cell Phone:**

Is client homebound? ☐ **YES** ☐ **NO-Cl must be homebound to qualify for services**

Reason for Homebound Status: _____

Is client aware of referral? ☐ **YES** ☐ **NO-Cl must be willing and able to participate in therapy**

Can the client utilize audio/visual Telehealth? ☐ **YES** ☐ **NO**

Does the client have the technology to utilize audio/visual Telehealth? ☐ **YES** ☐ **NO**

Does the client have access to Internet? ☐ **YES** ☐ **NO**

Primary Insurance Information: ***Complete ALL information below***

Medicare #: **Part B:** ☐ **YES** ☐ **NO**

Medicare Advantage Plan

Name/Type: ☐ **HMO** ☐ **PPO**

ID #: **Group #:**

Phone #:

Secondary or other Insurance:

Name/Type:

ID#: **Droup #:**

Phone #:

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

Reason for Referral:

Previous Mental Health Diagnosis and Treatment:

List Medical Conditions and Medications:

Physician: **Phone:**

THANK YOU FOR YOUR REFERRAL TO FAMILY ELDERCARE IN HOME COUNSELING

COUNSELING@FAMILYELDERCARE.ORG

FAX: 512.821.9813