

Adult Foster/Adult family Care MEMBER REFERRAL FORM

Date of Referral://		Langu	ıage: M		_ CG
Name:		Date o	of Birth:	/	
Address:		Telep	hone #:		
City, Zip Code:		Careg	iver:		
Referral Source:		Caregiver phone #:			
MassHealth ID #:		Socia	al Security #:		
Insurance Type: MassHealth Standard		Masshealth CommonHealth			
Date EVs Verified:	_SCO10	ARE	MCO W	ITH PCC	PACE
Primary Care Physician:		Pho	one:		
Address:		Fax	:		
Is PCP a MassHealth Provider?	If	no, then	stop referra	al and infor	m member of the
need for PCP to be MassHealth P	rovider to be ass	essed fo	or AFC eligib	lity.	
Current Medical Problems and Dia	agnosis				
<u>Diagnosis/Problem</u>	Date/Age or Onset				

ADL/Personal Care Needs: DAILY PHYSICAL ASSIST OR C&S DURING ENTIRE TASK (LEVEL 1)

Use Codes: I (Independent) D (Dependent) PA (Assist) CS (Cueing and Supervision)
Bathing:
Dressing:
Toileting/Incontinence Care:
Ambulating:
Eating:
Transferring:
How long can member be left unsupervised?
Behavioral/Cognitive/ Mental Health problems requiring Caregiver assistance up to 24 hours per day (Wandering, verbal/physical abuse, socially inappropriate behavior, resist care).
MEMBER/CG HAVE BEEN ADVISED TB'S WILL BE REQUIRED FOR BOTH (& PE FOR CG) BEFORE ORIENTATION CAN BE SCHEDULED? YES NO NO
Home Safety Checklist
Are there any firearms in the house?
If yes, is it licensed and where is it stored?
Are there any pets in the house? What type of pet(s)?
Does anyone in house have medical marijuana license?
Is there supplemental oxygen present in the home?
Does anyone in the house currently smoke cigarettes?
How did you find out about Tempus' AFC Program?

Other Supports/Providers: Emergency Contact: Phone: Rep Payee: Phone: Guardian: Phone: (IF PARENT IS GUARDIAN & WANTS T/B CG, GUARDIANSHIP MUST BE RELINQUISHED) Health Care Proxy: Phone: PCA/VNA/other in-home services: Phone: Present Day Services/ Phone: Schedule: