Client Referral Form

office (320)281-9018 NPI 1043902760

Email to: dericks@myadaptivepro.com

DATE _____

CLIENT INFORMATION.

First Name _____ Last Name _____

Date of Birth _____ PMI Number _____

Primary Phone_____ Alternate Phone _____

Email _____

Address _____ City/Zip Code _____

County _____ Does Client ☐Own ☐Rent ☐Belong to HOA

GUARDIAN INFORMATION.

First Name _____ Last Name _____

Primary Phone_____ Alternate Phone _____

Email _____ ☐ Decision Maker ☐ Contact for Scheduling

CASE MANAGER.

Name _____ Email _____

Primary Phone_____ Alternate Phone _____

Supervisor Name _____

Email_____ Phone_____

WAIVER/CDCS INFORMATION.

Waiver Type ☐AC ☐BI ☐CAC ☐CADI ☐DD ☐ EW Waiver Start Date _____

Medical Dx _____

CDCS ☐Yes ☐No Spend Down ☐Yes ☐No

CDCS Company _____ Contact Name _____

Phone_____ Email_____

SERVICE REQUESTED.

We would recommend an on-site consultation so we can get an idea of placement on the installation and what will be needed.

☐ Assistive Technology. ☐ Consoltation. ☐ Modifications/Adaptions. ☐ Training and set up.

☐ Other_____

AREAS TO BE ASSESSED

☐ Bathroom ☐Bedroom ☐Entrance ☐Exterior ☐Kitchen ☐ Other_____

NOTES

Please note: Services and fees accrue upon the submission of this form to Adaptive Home Solutions, LLC