

SENIOR CARE *that*

CHANGES LIVES.

ElderONE

An Affiliate of
Rochester Regional Health

REFERRAL FORM

Mission

To preserve and sustain the independence of chronically ill or disabled individuals by providing comprehensive medical care and support services that allow them to enjoy the highest quality of life in their own home and community.

Referral Criteria

To receive ElderONE services, an individual must *(please check all that apply)*:

- Be 55 years of age or older
- Be determined to need nursing home level of care (for more than 120 days)
- Capable of residing safely in the community with support services at time of enrollment
- Reside in ElderONE's service area (Monroe, Wayne, Ontario Counties)

Referral Information

First Name: _____ Last Name: _____

Address: *(Street)* _____ Age: _____ DOB: _____

(City) _____ *(State)* _____ *(Zip)* _____ Gender: Male Female Other

Insurance: Medicare Medicaid Medicare/Medicaid Private Unknown

Phone Number: *(Home)* _____ *(Cell)* _____

Family or Caregiver Name/Relationship: _____

Family or Caregiver Phone Number: *(Home)* _____ *(Cell)* _____

Referral Source

Name and/or Organization: _____

Contact Number: *(Home/Office)* _____ *(Cell)* _____

Email Address: _____ Fax: _____

PLEASE FAX COMPLETED FORM AND ANY SUPPORTIVE MEDICAL DOCUMENTATION (IF AVAILABLE) TO 585.922.2849 - ATTN: INTAKE OFFICE

Should you have any questions or need additional assistance, please call us directly at 585.922.2831.

Hudson PACE Center
2066 Hudson Avenue
Rochester, NY 14617

North Park PACE Center
335 North Park Drive
Rochester, NY 14609

Emerson PACE Center
800 Emerson Street
Rochester, NY 14613

Silver Hill PACE Center
1000 Technology Parkway
Newark, NY 14513