



3 West Road | Virks Building | Cranston, RI 02920

Attachment 2 - Assisted Living Enhanced Care Referral Form

Instructions: Complete this referral form and fax to OHA Case Management Agency

Section I: Referral Information

Today's Date: _____

Name of Referrer: _____ Phone: _____ Fax: _____

Assisted Living Residence: _____ Phone: _____

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

Section II: Client Information

Client Name: _____ Phone: _____

DOB: _____ SSN# _____

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

Primary Contact: _____ Relationship: _____ Phone: _____

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

	YES	NO	Comments
Currently on Medicaid AL Program?	Date: _____		
Currently receiving Category D?	Date: _____		
Applying for LTSS Medicaid?	Date: _____		
Current Income			

