



Aging & Disability Resource Center: 812-464-7817 available Monday through Friday 8:00AM-4:00PM

**Referral form for Options Counseling and Long-Term Services and Supports**

**Please FAX the 2-page referral form to 812-464-7843, or MAIL to**

**Attn: ADRC**

**SWIRCA**

**16 W. Virginia St**

**Evansville, IN 47710**

**Client or Client Representative:** I give permission for my clinical provider to give my name, address, phone number, and the client information below to SWIRCA & More so that a phone options counselor from SWIRCA & More may contact me or my personal representative about options that are available to me and my family. I understand that SWIRCA & More may provide feedback to my clinical provider based on our contact. ☐ Client/Client Representative consents to this referral

**Date:** \_\_\_\_\_

***Please Print Your Information Below***

**Client's Name** (person needing assistance) \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Email \_\_\_\_\_ Age \_\_\_\_\_

Primary disability type or diagnoses: \_\_\_\_\_  
\_\_\_\_\_

**Preferred point of contact (if not client)** \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Contact person: Phone \_\_\_\_\_, Email \_\_\_\_\_

**Professional or Clinical Referrals:**

Referral Source Name: \_\_\_\_\_ Agency/Clinic Name: \_\_\_\_\_

Contact Information: Phone \_\_\_\_\_, Email \_\_\_\_\_

**Disclaimer:** Client must agree to any assessment for services. If client cannot be reached due to incorrect contact information provided referral will not be completed.

**Identify client needs check all that apply** (*one checkmark is required to submit*):

- ☐ General information about long term services and supports
- ☐ Assistance with personal care (such as bathing, dressing, toileting, etc)
- ☐ Caregiver support/respite
- ☐ Emergency response alert buttons
- ☐ Home modifications/repairs/accessibility
- ☐ Housing (independent, assisted living, nursing facilities)
- ☐ Meals (home-delivered, meals sites, meal prep)
- ☐ Medical supplies or equipment (ex. adult diapers)
- ☐ Medicare or Medicaid counseling
- ☐ Public benefits application assistance (ex. SNAP)
- ☐ Support groups/friendly visiting/senior activities
- ☐ Transportation
- ☐ Other: \_\_\_\_\_  
\_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_