



**United HomeCare Services**  
CUSTOMER SERVICE/ADMISSION DEPARTMENT  
PHONE NUMBER **305-716-0710**  
FAX NUMBER **305-639-3093**

### Community Service Referral

Date of Referral: \_\_\_\_\_

Referred by: Case Mgmt \_\_\_\_\_ Medicare \_\_\_\_\_ Home Health \_\_\_\_\_ Other \_\_\_\_\_

Name of Case Mgr/ Referral Source: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Client's Name:** \_\_\_\_\_ **SS#** \_\_\_\_\_

SEX: FEMALE OR MALE (CIRCLE ONE) RACE: \_\_\_\_\_

Client's Address: \_\_\_\_\_

Client's D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAID #: \_\_\_\_\_

MEDICARE #: \_\_\_\_\_

Contact Telephone: \_\_\_\_\_

Client's next of Kin or Caregiver Contact: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Lives With Client? Yes No

Preferred Language: \_\_\_\_ Spanish \_\_\_\_ English \_\_\_\_ Creole \_\_\_\_ Other: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

#### Medicare Referral

If skill services are needed, please submit **Physician Order** and **Fact Sheet**.

Comments:

\_\_\_\_\_  
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