U & F Sons, Inc.

Sahara Home Care

www.saharahomecare.com

510 E. 22nd St,
Lombard, IL 60148
Tel: (630) 953-1950
Fax: (630) 953-1951

5200 Main Street
Skokie, IL 60077
Tel: (847) 329-8500
Fax: (847) 329-8501

2900 W.**Devon** Ave.
Chicago, IL 60659
Tel: (773) 274-1380
Fax: (773) 274-1381

2225 W. North Ave.
Melrose Park,IL 60160
Tel: (708) 344-2273
Fax: (708) 344-2277

1830 W.Army Trail Rd.
Hanover Park, IL 60133
Tel: (630) 372-2475
Fax: 630-372-2488

489 W. Boughton Road
Bolingbrook, IL 60440
Tel: (630) 679-1580
Fax: (630) 679-1581

8104 S. Roberts Rd.
Justice, IL 60458
Tel: (708) 594-2273
Fax: (708) 594-2217

1837 Larkin Ave.
Elgin, IL 60123
Tel: (847) 608-9352
Fax: (847) 608-9353

4310 W. Lawrence Ave.
Chicago, IL 60630
Tel: (773) 685-2273
Fax: (773) 685-2272

1717 W. Golf Road
Mount Prospect, IL 60056
Tel: (847) 427-2273
Fax: (847) 640-9204

1024 S McHenry Ave.
Crystal Lake, IL 60014
Tel: (815) 455-2273
Fax: (815) 455-2278

2502 S Alpine Rd,
Rockford, IL 61108
Tel: (779) 210-7151
Fax: (779) 210-7157

REFERRAL FORM FOR CCP HOMECARE PROGRAM

CONSENT TO RELEASE REFERRAL INFORMATION

U&F Sons, Inc./Sahara Asian Elderly Care recognizes that the nature of our services means that much of the information we handle is particularly sensitive. The information we collect will relate primarily to areas of health, community support and the protection of individual and public health and safety. We recognise the essential right of individuals to have their information handled in ways, which they would reasonably expect – protected on the one hand and made accessible to them on the other**. It is the policy of U&F Sons/SAEC to limit the exchange of confidential information concerning service users.**

If the client/guardian is unable to provide signed consent, has verbal consent been given? ☐ Yes ☐ No

I, (client/guardian)_____

hereby give consent for the Client of (address) _____

to provide the all relevant referral information to U & F Sons, Inc. for the purpose to receive CCP services.

Signature: _____ Date: _____ / _____ / _____

General Information

Last Name: _____ First Name: _____ Sex: _____

Social Security #: _____ - _____ - _____ Status: _____ Country of Birth: _____

Date Of Birth: _____ / _____ / _____ Age:_____ Language: _____ Marital Status: _____

Address: _____ Appt #:_____ Township: _____

City: _____ Zip Code: _____ - _____ County: _____

Tel: (_____) _____ - _____ Annual Income: $ _____ Source of Income: Other /_____

Medicaid : Applied Client's Type of residence: ☐Single Family House ☐Duplex ☐Condo ☐Townhouse

Does the client currently? ☐Rent ☐Owned ☐Living with _____

Emergency Contact

1) Spouse: _____ Cell: (_____) _____ - _____

2) Last Name: _____ First Name: _____

Relationship: _____ Tel: (_____) _____ - _____ Cell: (_____) _____ - _____

Address: _____

2) Last Name: _____ First Name: _____

Relationship: _____ Tel: (_____) _____ - _____ Cell: (_____) _____ - _____

Medical Information

Treating Doctor's Name: _____

Treating Doctor's Tel: (_____) _____ - _____

Diagnosis/Health Problems: ❑ Arthritis ❑ Bed bound ❑ Bowel/Bladder ❑ Cancer ❑ Deaf ❑ Depression ❑ Confused/Dementia ❑ Diabetes ❑ Frequent Falls ❑ High Blood Pressure ❑ Heart Problems ❑ Hard of Hearing ❑ Needs Supervision ❑ Paralysis ❑ Poor Ambulation ❑ Respiratory Problems ❑ Tremors ❑ Wheelchair ❑ Walker/Cane ❑ Seizure/Epilepsy ❑ Stroke Victim/CVA ❑ Visually Impaired/Blind

Describe Medical Condition and list all medications: _____

_____

_____

Other Information

Is the client in need of an interpreter at the time of assessment? ❑ Yes ❑ No

If so, what language? _____

Will the client require the presence of an advocate (independent, family member or friend) at the time of assessment?

❑ Yes ❑ No

If so, please provide their name, relationship to the client and contact details _____

What are the client's current support needs? ☐Using the telephone ☐Shopping ☐Preparing meals ☐Housekeeping ☐Doing laundry ☐Using transportation ☐Maintaining continence ☐Eating ☐Using the toilet ☐Bathing ☐Dressing

_____

Does the client have a medical condition requiring treatment? If so, please specify

_____

_____

ADDITIONAL INFORMATION: _____

_____

_____

_____

********** **FOR OFFICE USE ONLY** **********

Referral Received on: _____/ _____ / _____ Referral Received From: _____

Referred to Dept on: _____/ _____ / _____ Dept Visit (if Available) : _____/ _____ / _____

Remarks: _____

_____

_____

Case Status on _____/ _____ / _____ : ❑ Approved ❑ Not Approved ❑ Pending

Case Status on _____/ _____ / _____ : ❑ Approved ❑ Not Approved ❑ Pending

Supervisor Name: _____ Location: _____