

# St. Vincent PACE

## Intake Referral Form

Do you know of someone struggling with physical or cognitive challenges that is age 55 or older and lives in our service area (Select Zip Codes in Boone, Clinton, Delaware, Hamilton, Hancock, Hendricks, Madison, Marion, Morgan, Rush and Shelby counties)? Consider Ascension Living St. Vincent PACE. Our Intake Team can assess eligibility and ability to live in a home setting safely with our help.

To make a referral, please complete and fax or Email this form with any relevant medical records to Ascension Living St. Vincent PACE at: **Fax: 463-271-3750** | **Email: [PACEintakeIN@ascension.org](mailto:PACEintakeIN@ascension.org)**

### Referral Information

Has the person or family been informed of this referral:  Yes  No

Name: \_\_\_\_\_ Date of Birth (Must Be 55 or Older): \_\_\_\_\_ Gender: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Current Living Situation:  Own Home  Own Apartment  Lives with Family/Friend  Adult Foster Care

Insurance:  Medicaid  Medicare  Other: \_\_\_\_\_

Current Primary Care Physician: \_\_\_\_\_

**Caregiver/Support Person** (If applicable): \_\_\_\_\_

Relationship to Person Being Referred: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Current or recent challenges (Check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> Uses Canes, Walker, Wheelchair, Motorized Scooter | <input type="checkbox"/> Dialysis   |
| <input type="checkbox"/> Transferring Challenges (bed, chair, walker)      | <input type="checkbox"/> Confusion, Memory Challenges or Dementia                           |
| <input type="checkbox"/> Needs Assistance with Toileting                   | <input type="checkbox"/> Difficulty Managing Household Tasks                                |
| <input type="checkbox"/> Catheter or Ostomy Care                           | <input type="checkbox"/> Daily Oxygen Use or Regular Shortness of Breath                    |
| <input type="checkbox"/> Difficulty Completing Personal Care               | <input type="checkbox"/> Frequent Emergency Room Visits<br>(two or more in past two months) |

### Current services provided in the home (Check all that apply):

Nurse/CNA  PT/OT/SLP  Chore Provider  Other: \_\_\_\_\_

<b>Reason for PACE referral:</b>   
--

### Referring Contact (If different from Caregiver/Support Person above):

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship to person being referred: \_\_\_\_\_

Representing Organization/Title (if applicable): \_\_\_\_\_

A PACE team member will call the referred individual, caregiver/support person or referring contact within 1 to 2 business days. Thank you for your interest in Ascension Living St. Vincent PACE. **For more information, call us at 317-754-4565.**