Submit by **Mail:** **Catholic Charities**
Independent Support Services
PO Box 10660
Portland, ME 04104-6060
Fax: **(207) 299-1930**
Email: **ISSReferral@ccmaine.org**

Referral Form

- Our purpose is to help consumers live independently at home
- Consumers must be physically unable to complete their own homemaking tasks
- Services are provided no less than 8 hours a month on a long-term basis

Form must be filled in completely in order to process. Please write "N/A" where appropriate.

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1. Name of Consumer: ___________________________________ **2. DOB:** ___________________

Name of Spouse: ______________________________________ **DOB:**____________________

3. Address of Consumer: ____

4. Total Number in Household: _____ **5. Phone # of Consumer:** _________________________

6. Name, Agency & Phone # of person making referral, if other than consumer:

____

7. Emergency Contact Name, Relationship and Phone #: **(Should emergency contact be called on Consumer's behalf? □)**

____

8. (For those referring on behalf of Consumer) Does Consumer know they are being referred? ____________

9. Does Consumer have less than $50,000 in liquid assets (or less than $75,000 for a couple?) ________

10. Does Consumer know someone who could be their homemaker? Name: ____________________________________

11. Is Consumer currently on a waitlist for a MAXIMUS Health Systems assessment? ________________

Agencies/Services involved with consumer:____

Caregiver Status:

☐ **Primary Caregiver receives help from family or friends.**

☐ **Primary Caregiver is unable to continue because** ____

____

Consumer's IADL/ADL's Performance Scale:

Place number on the line which most closely describes consumer's present performance level.

1. Independently 2. Some Difficulty 3. Great Difficulty 4. Someone else must assist

_______ Laundry _______Grocery shopping

_______ Meal Preparation _______Banking

_______Meal Planning _______Picking up prescriptions

 (Continue on back)

______Light Housecleaning	______Taking out trash
______Washing floors/vacuuming	______Limited Assistance with Personal Hygiene, such as: combing/washing hair, washing face, putting on jacket or shoes to go out
______Cleaning bathtub/shower, toilet	Other____
______Changing/Making bed	

Medical Information:

Heart/Circulation	Current	History		Current	History
Congestive Heart Failure	□	□	Transient Ischemic Attack	□	□
Deep Vein Thrombosis	□	□	Stroke	□	□
Lymphedema	□	□	**Endocrine/Metabolic**		
Peripheral Vascular Disease	□	□	Diabetes Mellitus	□	□
Coronary Artery Disease	□	□	Hyperthyroidism	□	□
Musculoskeletal			Hypothyroidism	□	□
Rheumatoid Arthritis	□	□	**Pulmonary**		
Osteoarthritis	□	□	Emphysema	□	□
Osteoporosis	□	□	COPD	□	□
Fibromyalgia	□	□	On Oxygen	□	□
Muscular Dystrophy	□	□	Pulmonary Vascular Disease	□	□
Missing Limb (i.e. amputation)	□	□	**Sensory**		
Neurological			Macular Degeneration	□	□
Traumatic Brain Injury	□	□	Glaucoma	□	□
Alzheimer's	□	□	Cataracts	□	□
Dementia	□	□	Diabetic Neuropathy	□	□
Aphasia	□	□	Hard of Hearing	□	□
Cerebral Palsy	□	□	Deaf	□	□
Multiple Sclerosis	□	□	Legally Blind	□	□
Parkinson's Disease	□	□			

Cancer: Type: ___________________Current □ History □ Type: ___________________Current □ History □

Surgeries: Yes □ No □ 1. ____________________ 2. ____________________ 3. _____________________

Currently on Dialysis: Yes □ No □

Assistive devices used daily : □ Cane □ Wheelchair □ Walker/ Rollator □ Hearing Aids □ Other: ___________________

Other physical limitations: ____

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