AFFINITI CARE L.L.C

610-977-1045
affiniticare@gmail.com
www.afincare.org
26 Marple Avenue,
Clifton Heights, PA 1901

Affiniti Care L.L.C. HOME HEALTH / SKILLED NURSING & HOME CARE REFERRAL FORM

CONFIDENTIAL • HIPAA PROTECTED • FOR PROFESSIONAL USE ONLY

1 REFERRAL SOURCE INFORMATION

DATE OF REFERRAL

10/11/2026

URGENCY LEVEL

- [ ] Routine
- [ ] Urgent
- [ ] STAT
- [ ] SOC 24-48 hrs

REFERRED BY - NAME

Full name

TITLE / ROLE

RN, MSW, Case Mgr...

AGENCY / FACILITY

Hospital / SNF / Office

PHONE

( ) -

FAX

( ) -

EMAIL

referrer@...

HOSPITAL / FACILITY NAME

UNIT / FLOOR

CASE MANAGER / SOCIAL WORKER

RELATIONSHIP TO PATIENT

Case Mgr, Daughter...

HOW DID YOU HEAR ABOUT US?

Physician referral, website, previous patient...

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2 PATIENT DEMOGRAPHICS & CONTACT

LAST NAME | **FIRST NAME** | **MI**

DOB | **AGE**

10/11/2026 | Yrs

GENDER

☐ M ☐ F ☐ Other

STREET ADDRESS

CITY | **STATE** | **ZIP CODE**

PA

PHONE - HOME | **PHONE - CELL** | **EMAIL**

PREFERRED LANGUAGE

English, Spanish...

INTERPRETER NEEDED?

☐ Yes ☐ No

EMERGENCY CONTACT NAME | **RELATIONSHIP** | **PHONE**

POA / HCP NAME | **POA PHONE**

LIVING SITUATION

☐ Alone ☐ With Family ☐ With Spouse
☐ Facility / SNF / ALF ☐ Other

MARITAL STATUS | **SSN - LAST 4**

XXX-XX-____

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3 INSURANCE / PAYOR INFORMATION

PRIMARY INSURANCE / PAYOR TYPE

- [ ] Medicare
- [ ] Medicaid
- [ ] Private Insurance
- [ ] VA / Veterans
- [ ] LTC Insurance
- [ ] Private Pay
- [ ] Other

POLICY # / MEMBER ID

GROUP #

AUTH REQUIRED?

- [ ] Yes
- [ ] No

AUTH # / REFERENCE #

AUTH EFFECTIVE DATE

10/11/2026

SECONDARY INSURANCE

MEDICAID #

MEDICARE #

CASE MANAGER / INSURANCE CONTACT & PHONE

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4 PHYSICIAN INFORMATION & ORDERS

NOTE: For Medicare Home Health, Face-to-Face encounter and signed physician orders required. Please attach F2F and H&P.

PCP NAME

NPI #

PCP PHONE

PCP FAX

PCP ADDRESS

ORDERING PHYSICIAN (IF DIFFERENT)

NPI #

PHONE

FAX

LAST SEEN DATE

10/11/2026

NEXT APPOINTMENT

10/11/2026

PRIMARY DIAGNOSIS

e.g., Heart Failure, COPD...

ICD-10 CODE

I50.9

SECONDARY DIAGNOSIS

ICD-10

ADDITIONAL DIAGNOSIS 1

ICD-10 CODE

ADDITIONAL DIAGNOSIS 2

ICD-10 CODE

ADDITIONAL DIAGNOSIS 3

ICD-10 CODE

ALLERGIES

☐ NKDA

☐ Yes - List

ALLERGY 1 - AGENT / REACTION / SEVERITY

ALLERGY 2 - AGENT / REACTION / SEVERITY

ALLERGY 3

PROGNOSIS / EXPECTED DURATION OF SERVICES

Good, Fair, Poor - e.g., 60 days, chronic management...

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5 CLINICAL INFORMATION / REASON FOR REFERRAL

REASON FOR REFERRAL / SKILLED NEED / CLINICAL SUMMARY

Describe skilled need, recent change in condition, reason for home health, goals...

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ HTN / Hypertension
- ☐ Diabetes Type 1 / 2
- ☐ CHF / Heart Failure
- ☐ COPD / Emphysema
- ☐ CVA / Stroke / TIA
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Cancer - Type_____
- ☐ Heart Disease / CAD / MI
- ☐ Renal Disease / CKD / Dialysis
- ☐ Wound / Ulcer / Skin Breakdown
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Depression / Anxiety
- ☐ Fall History
- ☐ Other: _____

Cancer - Type_____

Other: _____

SURGICAL HISTORY / PROCEDURES / DATES

List surgeries with dates...

RECENT HOSPITALIZATION?

- ☐ Yes
- ☐ No

DATE OF ADMISSION / DISCHARGE

10/11/2026

REASON / ADMITTING DIAGNOSIS

DISCHARGE SUMMARY ATTACHED?

- ☐ Yes
- ☐ No

COGNITIVE STATUS

- ☐ Alert x3 (Person/Place/Time)
- ☐ Alert x2
- ☐ Alert x1
- ☐ Confused / Disoriented
- ☐ Non-Verbal
- ☐ Combative

FUNCTIONAL LIMITATIONS / DEFICITS

Weakness, limited ROM, bedbound...

FALL RISK?

- ☐ Yes - High Risk
- ☐ No / Low

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6 SERVICES REQUESTED - SKILLED NURSING & HOME HEALTH

SKILLED NURSING SERVICES

- [ ] Assessment / Evaluation & Case Management
- [ ] Wound Care - Dressing Change / Assessment
- [ ] Diabetic Teaching / Insulin Administration
- [ ] Ostomy Care / Teaching
- [ ] Injection Administration (IM/SQ)
- [ ] Vital Signs Monitoring / Teaching
- [ ] Patient / Family / Caregiver Education
- [ ] Other Skilled Nursing: _____
- [ ] Medication Management / Teaching
- [ ] Wound VAC / Negative Pressure
- [ ] Catheter Care / Foley Insertion / Change
- [ ] IV Therapy / Infusion / PICC Line Care
- [ ] Lab Draws / Specimen Collection
- [ ] Disease Management - CHF / COPD / Diabetes / HTN
- [ ] Post-Surgical Care / Suture / Staple Removal

Other Skilled Nursing: _____

THERAPY SERVICES

- [ ] Physical Therapy - Eval & Treat
- [ ] Speech Therapy - Eval & Treat / Swallow Eval
- [ ] Fall Prevention Program
- [ ] Occupational Therapy - Eval & Treat
- [ ] Gait Training / Safety Training
- [ ] Strengthening / ROM / Therapeutic Exercise

HOME HEALTH AIDE & SUPPORT

- [ ] Home Health Aide (HHA)
- [ ] Bathing / Hygiene
- [ ] Dressing
- [ ] Feeding Assistance
- [ ] Ambulation Assist
- [ ] Community Resources / Referral
- [ ] Personal Care Assistance
- [ ] Grooming
- [ ] Toileting / Incontinence Care
- [ ] Transfer Assist / Bed Mobility
- [ ] Medical Social Worker - Evaluation
- [ ] Counseling / Support / Psychosocial

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7 SERVICES REQUESTED - HOME CARE / NON-MEDICAL (PRIVATE DUTY)

NON-MEDICAL / COMPANION SERVICES

- [ ] Companion Care / Supervision
- [ ] Meal Preparation / Planning
- [ ] Transportation / Accompaniment
- [ ] Errands / Shopping
- [ ] 24-Hour Care / Continuous
- [ ] Hourly Care
- [ ] Homemaking / Light Housekeeping
- [ ] Laundry / Linen Change
- [ ] Medication Reminders (non-skilled)
- [ ] Respite Care for Family
- [ ] Live-In Care
- [ ] Overnight Care

HOURLY CARE - HOURS PER DAY

e.g., 4, 8, 12

DAYS PER WEEK

e.g., 5x, 7x, M-F

LEVEL / FREQUENCY

- [ ] 1:1 Continuous
- [ ] Daily
- [ ] Intermittent / Visit
- [ ] Weekly / PRN

DESIRED START DATE

10/11/2026

SCHEDULE PREFERENCES / DAYS & TIMES

M-F 9am-1pm, Weekends...

SPECIAL INSTRUCTIONS / PREFERENCES (PETS, LANGUAGE, CAREGIVER GENDER PREF., ETC.)

ADDITIONAL NOTES / CARE PLAN CONSIDERATIONS

Likes/dislikes, routines, behaviors, family dynamics...

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8 FUNCTIONAL STATUS, DME, SAFETY ASSESSMENT

ADLS - ACTIVITIES OF DAILY LIVING (INDEPENDENT / NEEDS ASSIST)

- [ ] Bathing: I / A
- [ ] Dressing: I / A
- [ ] Transfer / Bed Mobility: I / A
- [ ] Ambulation: I / A / Walker / WC
- [ ] Toileting: I / A
- [ ] Eating / Feeding: I / A
- [ ] Continence: I / A / Incontinent

IADLS - INSTRUMENTAL ADLS

- [ ] Meal Prep: I / A
- [ ] Transportation: I / A
- [ ] Housekeeping: I / A
- [ ] Phone Use: I / A
- [ ] Med Management: I / A
- [ ] Finances / Money Mgmt: I / A
- [ ] Shopping: I / A
- [ ] Laundry: I / A

DME - DURABLE MEDICAL EQUIPMENT

- [ ] Walker
- [ ] Cane / Crutches
- [ ] Bedside Commode
- [ ] Nebulizer / CPAP / BiPAP
- [ ] Shower Chair
- [ ] Wheelchair
- [ ] Hospital Bed
- [ ] Oxygen / O2 Concentrator
- [ ] Hoyer Lift
- [ ] Other: _____

Other: _____

SAFETY / HOME ENVIRONMENT

- [ ] Fall Risk - High
- [ ] Home Hazards / Unsafe
- [ ] Smoking in Home
- [ ] Poor Lighting
- [ ] Other: _____
- [ ] Clutter / Hoarding
- [ ] Pets - Dogs / Cats
- [ ] Weapons in Home
- [ ] Stairs / No Elevator

Other: _____

COGNITIVE / BEHAVIORAL ISSUES

- [ ] Wandering / Elopement
- [ ] Non-Compliant / Refuses Care
- [ ] Depression / Withdrawn
- [ ] Hallucinations
- [ ] Aggressive / Combative
- [ ] Anxiety / Agitation
- [ ] Sundowning
- [ ] Substance Use

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9 ADDITIONAL INFORMATION & DOCUMENTS ATTACHED

PLEASE ATTACH / CHECK DOCUMENTS INCLUDED WITH THIS REFERRAL

- ☐ Current Medication List / MAR
- ☐ Physician Orders / 485
- ☐ Insurance Card Copy - Front & Back
- ☐ Recent Lab Results / Diagnostics
- ☐ Therapy Notes / Eval (PT/OT/ST)
- ☐ Advance Directives / POLST / DNR
- ☐ Face-to-Face Encounter Note & Date
- ☐ Demographics Sheet / Face Sheet
- ☐ History & Physical (H&P)
- ☐ Discharge Summary / DC Instructions
- ☐ Wound Photos / Measurements / Orders
- ☐ Other: _____

Other: _____

ADDITIONAL COMMENTS / SPECIAL CONSIDERATIONS / FAMILY CONCERNS / GOALS

Include any other relevant information for care planning, precautions, infection status, isolation, COVID/flu, etc.

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10 CONSENT, SIGNATURE & AGENCY USE ONLY

PERSON COMPLETING REFERRAL / REFERRER ATTESTATION

PRINT NAME

TITLE / CREDENTIALS

SIGNATURE (TYPE FULL NAME TO E-SIGN)

Type name as electronic signature

DATE

10/11/2026

TIME

12:30 PM

PHONE

EMAIL

AGENCY / FACILITY / OFFICE

☐ I certify that the information provided is true and accurate to the best of my knowledge. I understand that Affiniti Care L.L.C. will verify insurance eligibility, obtain necessary physician orders, and contact patient/family for Start of Care coordination. I authorize release of necessary medical information for care coordination and billing purposes in compliance with HIPAA. Patient (or POA) has been informed of referral to home health/home care services.

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AGENCY USE ONLY - INTAKE / ADMISSIONS

Internal - Do not write above

DATE RECEIVED: 10/11/2026

TIME RECEIVED: 12:30 PM

RECEIVED BY (INITIALS):

ASSIGNED NURSE / CLINICIAN / AIDE:

SOC DATE SCHEDULED: 10/11/2026

STATUS

- [ ] Accepted
- [ ] Pending
- [ ] Declined

REASON IF DECLINED / PENDING:

COMMENTS / FOLLOW-UP ACTIONS:

INSURANCE VERIFIED BY & DATE:

AUTH OBTAINED # / DATE:

MD ORDERS RECEIVED DATE: 10/11/2026

URGENT REFERRALS - IMMEDIATE RESPONSE PROTOCOL

For immediate needs, call 610-977-1045. We provide 24-48 hour Start of Care for qualified referrals. Our clinical team is available 24/7 for hospital discharges, urgent wound care, post-surgical needs, and new patient evaluations. Thank you for choosing Affiniti Care L.L.C. - Providing Compassionate, Professional Home Health & Home Care Since 2010. We appreciate your trust in our care team.

This form contains confidential health information protected by state and federal law, including HIPAA. If you received this in error, please contact Affiniti Care immediately and destroy the document. Do not copy or distribute.