Chatham County Public Health Department
Community Alternatives Program
Referral Form
*****Fax to 919-742-7496*****

Applicant First Name: _____

Applicant Last Name: _____

Medicare ID: _____ **DOB:** _____ **Gender:** ☐ **Male** ☐ **Female**

Primary Contact Person: ☐ **Applicant** ☐ **Other Representative**

If Contact Other than Applicant (First and Last Name): _____

Legal Guardian in Place: ☐ **Yes** ☐ **No**

Current Living Arrangement: ☐ **Private Residence** ☐ **Hospital** ☐ **Nursing Facility** ☐ **Other**

Primary Language Spoken in Household: _____

Is Interpreter (spoken) or Translator (written) needed or wanted? ☐ **Yes** ☐ **No**

Hospital/Nursing Facility/Temporary Living Facility (if applicable)

Name: _____

Anticipated Discharge Date: _____

Name of Discharge Planner: _____

Discharge Planner Telephone: _____

Hospital/Facility Comments: _____

Applicant Full Address: _____

Applicant County: _____ **Telephone #:** _____

Referrer Name: _____

Relationship to Applicant: _____

Contact #: _____

For your privacy and security, printed referrals should be faxed.

*****DO NOT EMAIL REFERRALS*****