EquaCare LLC

REFERRAL FORM

Please complete all applicable sections.

3839 Merle Hay Rd, Ste 204
Des Moines, IA 50310
515-508-1556 | Fax 515-335-2050
equacare77@gmail.com
www.equacarellc.com

Date of Referral:

1. MEMBER INFORMATION

Member Name: **DOB:**

Medicaid #: **Address:**

Cell Phone: **Email:**

Parent/Guardian/Caregiver Name:

Phone: **Email:**

2. WAIVER & SERVICE REQUEST

Waiver Type: ☐ ID ☐ Brain Injury ☐ Physical Disability ☐ Elderly ☐ H&D ☐ AIDS/HIV ☐ Other:

Service: ☐ CDAC (Personal Care / Companion / Homemaker) ☐ Respite ☐ SCL ☐ Other:

Preferred Days: **Requested Hours:**

MCO: ☐ Molina ☐ Iowa Total Care ☐ Wellpoint ☐ Other: **Policy #:**

3. CASE MANAGER / REFERRAL SOURCE

Case Manager: **Agency:**

Phone: **Email:**

Referral Source/Name: **Role:**

Phone: **Email:**

4. SERVICES NEEDED

☐ Dressing ☐ Bathing ☐ Meal Prep
☐ Toilet Assistance ☐ Transferring ☐ Cleaning
☐ Grocery Shopping ☐ Laundry ☐ Minor Wound Care
☐ Scheduling & Financial Assistance ☐ Communication ☐ Transportation
☐ Medication Assistance

5. ADDITIONAL REFERRAL INFORMATION

Language / Communication Preference:

Additional Information / Special Needs:

Return completed form by secure fax (515-335-2050) or encrypted email (equacare77@gmail.com).

CONFIDENTIAL: This form contains confidential member information intended solely for EquaCare LLC and authorized referral sources.