



**Upper Cumberland Area Agency on Aging and Disability  
Information and Assistance Referral Form  
Toll Free 1-866-836-6678**

**Referral Process**

1. The Client and/or family member must be aware that this referral is being submitted for in-home services.
2. Referral information form must be fully completed. If not, it will be returned to the referring individual.
3. Send the completed form to: Fax # 931-432-4267, jpruett@ucdd.org, or mail to Attention: AAAD Information and Assistance at 1225 South Willow Ave, Cookeville, Tn 38506

Referring Agency _____ Referring Individual Name/Phone _____	
Client's name _____	Date of Birth _____
Clients Address _____	
SS# _____	Telephone _____
Client Lives: ___ Alone ___ With Spouse ___ With Child ___ Other _____	Monthly Income _____
Primary Caregiver/Family Member Name _____	Telephone _____
Who do we contact for a screening? _____	Telephone _____
<b>What assistance does the client need? (Check all that apply)</b>	
_____ Choices _____ Bathing/personal care _____ Housecleaning/Homemaker Servies _____ Meals	
_____ Respite Care Services _____ Other _____	
I have informed the above client or family member that this referral is being made and have completed this information with their assistance and approval.	
_____	_____
<b>Referring Individual Signature</b>	<b>Date</b>

**Signatures For Release of Information**

**(optional)**

I give the above referenced agency permission to receive information about my eligibility status and services I may receive from the Upper Cumberland Area Agency on Aging & Disability (UCAAAD) and their service providers. I understand this information will not be shared without my written consent. **If this section is not completed UCAAAD can not release personal information.**

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<b>Client or Family Member Signature</b>	<b>Relationship If Not Client</b>	<b>Date</b>
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