

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. The referral information form must be fully completed. If not, it will be returned to the referring individual.
3. Send the completed form to: Fax # 931-476-4086, infoassist@ucdd.org, or mail to Attention: AAAD Information and Assistance at 1104 England Drive, Cookeville, TN 38501. **Referrals expire 6 months after signed.**

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 _____		
What assistance does the client need? (Check all that apply)		
<input type="checkbox"/> Choices <input type="checkbox"/> Bathing/Personal Care <input type="checkbox"/> Housecleaning/Homemaker Servies		
<input type="checkbox"/> Meals <input type="checkbox"/> Respite Care Services <input type="checkbox"/> 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.		
_____	_____	
Referring Individual Signature	Date	
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 cannot release personal information.		
_____	_____	_____
Client or Family Member Signature	Relationship If Not Client	Date

