** Social Work Referral Form**

**INSTRUCTIONS:** Please complete and return this form.

* By Mail to: PO Box 3459, Spring Hill, FL 34611
* Or Fax: 352-515-5980
* Or E-mail: CareManagement@ulthp.com

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| **Member Information** |

|  |  |
| --- | --- |
| **FIRST AND LAST NAME** | **MEMBER ID#** |
| **BIRTHDATE** (MM/DD/YYYY) | **PREFERRED PHONE NUMBER** |

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| **Check all that apply:** |

1. **Are you currently receiving Social Security or Disability** **benefits?**   
   🞏 Yes 🞏 No
2. **Are you currently homeless?**   
   🞏 Yes 🞏 No
3. **Are you currently receiving assistance from the Florida Food Assistance Program (SNAP)?**  
   🞏 Yes 🞏 No
4. **Do you have regular access to food?**   
   🞏 Yes 🞏 No
5. **Have you been admitted to the hospital in the last 6 months****?**   
   🞏 Yes 🞏 No
6. **Are you currently having difficulties paying for your copays or medications?**   
   🞏 Yes 🞏 No
7. **Would you like to be connected with a mental health therapist?**   
   🞏 Yes 🞏 No
8. **Do you have trouble finding transportation to medical and other appointments?**🞏 Yes 🞏 No
9. **Reason for Referral:** (List all of the community services needed.)

***Confidentiality Notice:*** *This facsimile and/or email message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or otherwise be protected by law. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.*