

# 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](mailto:CareManagement@ulthp.com)

## Member Information

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

## 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.