Social Work Referral Form

INSTRUCTIONS: Please complete and return this form.

- By Mail to: PO Box 3459, Spring Hill, FL 34611
- Or Fax: 352-580-5552
- Or E-mail: CareManagement@ulthp.com

ULTIMATE HEALTH PLANS

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.)