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: <u>CareManagement@ulthp.com</u>



Member Information			
FIRST AND LAST NAME		MEMBER ID#	
BIR	RTHDATE (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 med	lical and other appointments?	
	☐ Yes ☐ No		
9.	Reason for Referral: (List all of the community services needed.)		

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