



# SIGN UP/REFERRAL FORM FOR Bennington County - Arlington/Manchester Area

If you or a person you know might benefit from SASH, please complete this form and fax or mail it back to us. **SASH is a FREE program available to Medicare recipients.** (In rare cases SASH may be available to non-Medicare recipients; contact us for information.)

Your Name:\* \_\_\_\_\_

Your Phone Number:\* \_\_\_\_\_

Your Email Address: \_\_\_\_\_

Name of Referring Organization (if applicable): \_\_\_\_\_

Name of Person You Are Referring or Enrolling \* \_\_\_\_\_  
(This is the "enrollee." Enter "Same" if you are enrolling yourself.)

Enrollee's Date of Birth:\* \_\_\_\_\_

Does Enrollee Have Medicare?\*  Yes  No      Does Enrollee Have Medicaid?\*  Yes  No

Enrollee's Address: Street/911 Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Enrollee's Phone Number:\* \_\_\_\_\_  
(Enter "Same" if you are enrolling yourself.)

Enrollee's Primary Care Physician: \_\_\_\_\_

Enrollee's Primary Care Location: \_\_\_\_\_

Other Services Currently in Place for Enrollee:  Agency on Aging    Mental Health Support  
 Home Health/Skilled Nursing    Meals on Wheels    Homemaker/Personal Care

Please List Contact Information for Agency Support Providers: \_\_\_\_\_  
\_\_\_\_\_

Your Relationship to the Enrollee: \_\_\_\_\_

Enter Date Enrollee Consented to SASH Referral (if applicable): \_\_\_\_\_

Should We Contact the Enrollee Directly? \*  Yes  No

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*Please return this form or direct questions to:*  
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