SASH® a caring partnership
SUPPORT AND SERVICES AT HOME

SIGN UP/REFERRAL FORM FOR
Franklin Co.- Swanton/Highgate 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

Please return this form or direct questions to:

Pam Hunt, SASH Coordinator
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