



SIGN UP/REFERRAL FORM

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: * _____

Why are you referring this person to SASH? * _____

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: ☐ Case Management ☐ Agency on Aging
☐ Mental Health Support ☐ Home Health/Skilled Nursing ☐ Meals on Wheels ☐ Homemaker/Personal Care
(Please note: SASH does not provide case management but works with case managers to help meet participants' needs.)

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:

SASH

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