



Submit by Mail: Catholic Charities
 Independent Support Services
 420 Cumberland Ave
 Portland, ME 04101
 Fax: (207) 299-1930
 Email: ISSReferral@ccmaine.org

Referral Form

- Our purpose is to help consumers live independently at home
- Consumers must be physically unable to complete their own homemaking tasks
- Services are provided no less than 8 hours a month on a long-term basis

Form must be filled in completely in order to process. Please write "N/A" where appropriate.

1. Name of Consumer: _____ 2. DOB: _____

Name of Spouse: _____ DOB: _____

3. Address of Consumer: _____

4. Total Number in Household: _____ 5. Phone # of Consumer: _____

6. Name, Agency & Phone # of person making referral, if other than consumer: _____ APS _____ Step-Down

7. Emergency Contact Name, Relationship and Phone #: (Should emergency contact be called on Consumer's behalf?)

8. (For those referring on behalf of Consumer) Does Consumer know they are being referred? _____

9. Does Consumer have less than \$50,000 in liquid assets (or less than \$75,000 for a couple?) _____

10. Does Consumer know someone who could be their homemaker? Name: _____

11. Is Consumer currently on a waitlist for a Maximus assessment?

Agencies/Services involved with consumer: _____

Caregiver Status:

Primary Caregiver receives help from family or friends.

Primary Caregiver is unable to continue because _____

Consumer's IADL/ADL's Performance Scale:

Place number on the line which most closely describes consumer's present performance level.

1. Independently 2. Some Difficulty 3. Great Difficulty 4. Someone else must assist

_____ Laundry

_____ Grocery shopping

_____ Meal Preparation

_____ Errands

_____Light Housecleaning

_____Taking out trash

_____Limited Assistance with Personal Hygiene,
such as: combing/washing hair, washing face,
putting on jacket or shoes to go out

Other _____

Medical Information:

Heart/Circulation

Current History

Congestive Heart Failure

Deep Vein Thrombosis

Lymphedema

Peripheral Vascular Disease

Coronary Artery Disease

Musculoskeletal

Rheumatoid Arthritis

Osteoarthritis

Osteoporosis

Fibromyalgia

Muscular Dystrophy

Missing Limb (i.e. amputation)

Neurological

Traumatic Brain Injury

Alzheimer's

Dementia

Aphasia

Cerebral Palsy

Multiple Sclerosis

Parkinson's Disease

Transient Ischemic Attack

Stroke

Endocrine/Metabolic

Diabetes Mellitus

Hyperthyroidism

Hypothyroidism

Pulmonary

Emphysema

COPD

On Oxygen

Pulmonary Vascular Disease

Sensory

Macular Degeneration

Glaucoma

Cataracts

Diabetic Neuropathy

Hard of Hearing

Deaf

Legally Blind

Cancer: Type: _____ Current History

Type: _____ Current History

Surgeries: Yes No 1. _____ 2. _____ 3. _____

Currently on Dialysis: Yes No

Assistive devices used daily: Cane Wheelchair Walker/ Rollator Hearing Aids Other: _____

Other physical limitations: _____