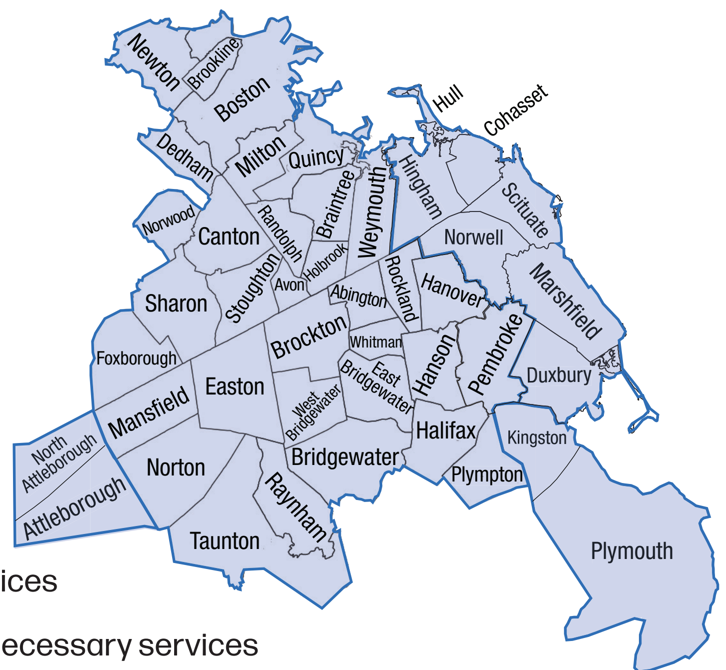
REFERRAL FORM

Thank you for your interest in the Harbor Health Elder Service Plan.

(774) 470-6700
espinfo@hhsi.us

Harbor Health PACE, a non-profit healthcare organization, has been serving the community since 1996. Harbor Health serves older adults with personalized healthcare and home support services provided by one dedicated geriatric team.



PACE Services and Support

- ✔ Primary, specialty and emergency medical care
- ✔ Home care including nursing and personal care
- ✔ Medications
- ✔ Transportation
- ✔ Adult Day Health Center
- ✔ Physical and Occupational therapy
- ✔ Behavioral health, counseling, and social work services
- ✔ Dental, Optometry, Audiology and other medically necessary services

You may qualify if you are:

- Age 55 plus, (if 55 to 64 must be disabled)
- Live in our service area
- Requires assistance at home with activities of daily living to remain safe and independent.

Applicants do not have to be enrolled in MassHealth standard, we will apply on their behalf.

To begin the PACE application please complete the top portion of the form. Please submit the referral form by email at ESPInFo@hhsi.us or fax (774) 470-6717 to initiate the process.

APPLICANTS' INFORMATION

First name ______________________________ Last name _______________________________

Address ____

Date of Birth _________________

Who is the primary contact for the PACE enrollment process?

Name ______________________________ Organization/Relationship ________________________

Phone _______________________

Email (preferred contact phone/email) ____

If applicant is less than 65 years old, are they disabled? Yes ___ No___

Is English the applicants primary language? Yes ___ No___

If no, what is preferred language for an interpreter? ______________________________

The following information is helpful to expedite the enrollment process, please complete as much as possible, if you do not have the information available to you, we can complete this portion later.

CONTACTS

Financial contact ______________________________ Phone ____________________

Email __________________________________

Health Care Proxy _____________________________ Phone____________________

Email __________________________________

Is applicant enrolled in Medicare? Yes ___ No___ ID number ________________________________

Is applicant enrolled in Medicaid (MassHealth)? Yes ___ No___ ID Number____________________

HEALTH STATUS

Current medical concerns/home support needs/diagnosis _______________________________________

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Are home support services in place? Yes ___ No___ What type of services_________________________

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Thank you for taking the time to fill out this referral form.
We will do all we can to expedite the enrollment process.