Referral Date: _____

CareStar®
Improving Communities By Improving Lives

HAMILTON COUNTY
SENIOR PATIENT NAVIGATION REFERRAL FORM

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____
Last *First* *M.I.* *(Applicant must be 60 years of age or older)*

Address: _____
(Applicant must be a resident of Hamilton County) *Street Address* *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____ Referral Source: CareStar

Please list any communication barriers: _____

LEGAL GUARDIAN

Full Name: _____ Phone: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Do you have a State ID or Social Security Card? YES ☐ NO ☐

Are you receiving services with Council on Aging? YES ☐ NO ☐

COMMUNITY CONNECTIONS NEEDED *(Please explain the reason for your application).*

Who else might we contact about the person being referred?

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

What is the best time to reach you, and/or the person named above?

SIGNATURE

Signature: _____ Date: _____

Submit this completed form to:

CareStar Inc.
5566 Cheviot Road
Cincinnati, OH 45247
Toll Free: 1-800-616-3718; Fax: 513-618-8319
PatientNavigation@carestar.com