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Basic HCBS Referral Form

First Tennessee Area Agency on Aging & Disability
3211 North Roan Street, Johnson City TN 37601
423-928-3258 Fax 423-926-8291

To make a referral for in-home services, please complete and mail,
fax or email the following information or have the information available when you call.

Client/Consumer Information

Date

Last Name | First Name | Initial

Address | City | TN, Zip | County

Phone

DOB | SSN | Male / Female

Caregiver Information

Caregiver information is needed for possible referral to caregiver programs

Caregiver's Name | Relationship

Address | City | TN, Zip | County

Phone

Availability

DOB | SSN

Medical Information for Client/Consumer

Primary Physician | Phone

Diagnosis

Cognitive Impairment? | Reason

Medicaid? | Provider

Financial and Residential Information for Client/Consumer

Do you have assets over $2,000 (if single) or $3,000 (if married)?

Monthly Income | Savings

You | your home | You live with

What Services are needed? | HMS | Meals | PC | Other

Referred by | Phone

Agency | Fax

If you would like a follow-up about your referral please provide an email address:

Please note that if you choose to email this form to us, it is recommended that you use encrypted technology to safeguard the personal and confidential information found on this form during email transmission. Please contact your email provider or IT person for more information on email encryption technology. If you are a Covered Entity who should follow HIPAA laws, this may be mandatory for you.