



June 1, 2011

Hello!

We are now in the planning stage for the SE Ohio ADRN. In addressing the first program component/core function of an ADRN as defined by the Centers for Medicare & Medicaid and the Administration on Aging, *Information, Referral and Awareness*, we are asking that you participate in the process by providing your input through this survey.

Enclosed is the referral grid developed by the State of Ohio. This grid defines the different types of referrals and illustrates how each should be handled. The three types of referrals that will be addressed by the information gathered through this survey are "facilitated", "active", and "warm".

The goal of this exercise is to establish a point referral process in which a specific person, staff position or department at each agency is identified as the agency contact for receipt of a referral. This information will help to create a systematic process across all operating partners to efficiently perform referrals and assist the clients who are seeking assistance. If referrals to your agency need to be directed to different departments depending on the presenting need of the client, please make additional copies of this survey and complete appropriately.

Please answer the survey questions and return to me via fax at 740-373-1594. Thank you in advance for your participation in the ADRN process. The compiled responses will be distributed and discussed at a future SE Ohio ADRN meeting.

Thank you in advance for your participation.

Sincerely,

Mindy Cayton, Planner
Area Agency on Aging 8



ADRN Survey – Referrals

1. When a referral is made to your agency, what information would be most helpful to expedite assistance to the client? Please rank the following data elements with a 1, 2 or 3 with 1 being the most desirable information and 3 being the least desirable.

- _____ Why are you calling today?
- _____ Client Name
- _____ Client Phone
- _____ Client Date of Birth
- _____ Are you currently getting services?
- _____ Living arrangements
- _____ Client Address
- _____ Referent Name
- _____ Referent Phone
- _____ Is there anyone who helps you make decisions?
- _____ Client County
- _____ Consent to share information on a need to know basis?
- _____ Client Gender
- _____ Current benefits
- _____ Primary disability
- _____ Funding source and waiver services
- _____ Client SS# (last 4 digits)
- _____ Client Marital Status
- _____ Referent Address
- _____ Relationship to Client
- _____ Medical insurance
- _____ Monthly Gross Income Ranges
- _____ Employment Status
- _____ Client Primary Language
- _____ Have you ever been determined by the government to have been disabled?
- _____ Outcome/Referral Information

2. How would you prefer to receive the information?

- _____ Phone call
- _____ Fax
- _____ Other _____



3. Who is your agency's point person, staff position or department for receipt of referrals?

Name: _____

Department: _____

Position: _____

Phone: _____

E-mail: _____

Fax: _____

Other helpful information:

Name of person completing this survey: _____

Position: _____

Agency name: _____

Phone: _____

E-Mail: _____

Please fax your completed survey to 740-373-1594 to the attention of Mindy Cayton, AAA8 Planner.