



Submit by Mail: Catholic Charities
Independent Support Services
P.O Box 10660
Portland, ME 04104
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 more 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. Will Consumer need an interpreter? If so, please indicate language: _____

7. Does consumer give permission for CCM to speak with referent? Yes No
Please provide Name, Agency & Phone # of person making referral, if other than consumer: _____

8. Does consumer give permission for CCM to speak with emergency contact? Yes No
Name, Relationship & Phone # of emergency contact: _____

9. Does Consumer know they are being referred? Yes No

10. Does Consumer have less than \$50,000 in liquid assets (or less than \$75,000 for a couple?) Yes No

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

12. Is Consumer currently on a waitlist for a Maxiumus assessment? Yes No

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	_____ Limited Assistance with Personal Hygiene, such as: combing/washing hair, washing face, putting on jacket or shoes to go out
_____ Meal Preparation	_____ Errands	
_____ Housekeeping	_____ Trash Removal	Other _____