Senior LinkAge Line® 1-800-333-2433
A One Stop Shop for Minnesota Seniors

Please complete and fax to 1-877-783-4053
All fields marked in red and have * are required.

This referral protocol pertains to Minnesota residents, age 60 or older, who are discharging to or are currently residing at home, regardless of insurance. Home can include a Registered Housing with Services setting, apartment or single dwelling.

Areas that Require Follow-Up*:

☐**Lack of caregiver or current caregiver is overwhelmed**

A caregiver is anyone who helps the patient with tasks of daily living; examples of persons filling this role are a family member, a friend or neighbor, or a paid provider. Tasks may include: groceries, medications, rides, chores, laundry, meals, walking, bathing or grooming, medical appointments, legal affairs, money or banking assistance, companionship, or supervision.

1. Do you worry or feel concern about continuing to care for the person who needs help? Do you feel they are becoming frail due to age or health condition?
2. Do you feel overwhelmed by the activities of being a caregiver while managing your own personal life?
3. Do you have to give up things that you would normally do such as spending time with family or friends?

☐**Needs help arranging non-health related services such as preparing meals, respite, laundry, housekeeping, chore or caregiver consultation services**

1. Do you need help preparing your home in order to live on your own?
2. Are you able to maintain the daily tasks of keeping a home like laundry, cleaning or yard work?
3. Are you able to pay for the help you need around the house?

☐**Needs assistance managing/paying for medications**

1. Are you able to get your medicine, for example, picking up prescriptions or arranging delivery from the pharmacy or getting prescriptions refilled as needed?
2. Do you have difficulty paying for your medicine?
3. Do you have a way to organize your prescriptions to help you take them on schedule?
4. Do you know where to go to find out more information about the medicines you are taking?

☐**Questions about Medicare or other health insurance benefits**

1. Do you have difficulty understanding your medical bills?
2. Do you need help exploring your health insurance or long-term care insurance options?
3. Do you need help to pay for your prescriptions?
4. Are you aware of the Medicare Savings Programs (For those who qualify – this program pays for Medicare premiums, co-pays and coinsurance)?

☐**No transportation or has difficulty getting places**

1. Do you need help getting to and from appointments?
2. Do you need help with shopping?
3. Do you have concerns about driving?
4. Have you been able to visit your friends and family as often as you would like? Or participate in community activities?

☐**Difficulty managing finances or paying for services**

1. Do you have several unpaid bills?
2. Are you able to find housing you can afford?
3. Do you need financial help to help pay for services such as utilities and phone bills?

☐**Memory concerns**

1. Do you have memory concerns that disrupt daily life?
2. Have you noticed challenges in planning or solving problems?
3. Do you have any concerns about wandering or getting lost?

☐**Concerns about safety or need for home modification**

1. For you to continue to live in your home; are repairs and/or remodeling needed?
2. Are you concerned about your risk of falling?

Type of Provider*:

☐ Hospital ☐ Certified Health Care Home

Provider Name*: _____

Provider Address*: _____

Provider City*: _____

Referral Source's First & Last Name*: _____

Referral Source's Title*:

☐ Discharge Planner/Social Worker ☐ Clerical Staff ☐ Registered Nurse

☐ Licensed Practical Nurse (LPN) ☐ Medical Assistant ☐ Physician

Referral Source's Phone Number*:

Patient's First & Last Name*:

Patient's Date of Birth*:

Patient's Gender*:

☐ Female ☐ Male

☐ Transgender- Female to Male ☐ Transgender-Male to Female

Patient's Home Address*:

Patient's Home City*:

Patient's Home County*:

Patient's Home Zip Code*:

Patient's Phone Number (Where patient can be reached for Long Term Care Options Counseling)*:

☐Please indicate if contact should be made with someone other than the patient and complete caregiver section below

Caregiver's First & Last Name:

Caregiver's Relationship:

☐ Adult Child ☐ Friend/Neighbor ☐ Guardian ☐ Other Relative ☐ Paid Help

☐ Parent of Adult ☐ Parent of Minor ☐ Relative ☐ Representative ☐ Service Provider

☐ Sibling ☐ Spouse/Partner

Caregiver Phone Number:

Date patient/caregiver would prefer follow-up from Senior LinkAge Line® (Should be at least 3 days from Referral date*:

Actual/Anticipated Discharge Date (Hospital Providers Only):

Is the patient going home with Medicare home care services?*:

☐ Yes ☐ No ☐ Unsure

Does the patient speak a language other than English and need translation services?*:

☐ Yes ☐ No

If yes, which language:

- [ ] American Sign Language (ASL)
- [ ] Amheric
- [ ] Arabic
- [ ] Chinese
- [ ] Hmong
- [ ] Khmer (Cambodian)
- [ ] Laotion
- [ ] Oromo
- [ ] Russian
- [ ] Serb-Croatian (Bosnian)
- [ ] Somali
- [ ] Spanish
- [ ] Vietnamese
- [ ] If other, please list the language spoken:

Does the patient need any special accommodations to receive this phone call?*:

- [ ] Yes
- [ ] No

If yes, what are the Special Accommodations?:

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Minnesota Hospital and Health Care Home Referrals to Senior LinkAge Line®

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If the patient has mental health concerns, they should be referred to the adult mental health unit at the county. You can find local county contact information at http://www.dhs.state.mn.us/main/id_000297.

If you are concerned about abuse, neglect (or self-neglect) or fininacial exploitation, a referral should be made to the Common Entry Point (CEP). You can find local county contact information at http://www.dhs.state.mn.us/main/id_005710.

If you are referring the patient (60+) to the county for a Long Term Care Consultation (LTCC), to apply for public benefits or other referrals, a referral to Senior LinkAge Line® is not needed.

If the patient is part of a managed care plan that covers both their Medicare and Medicaid benefits, please refer the patient to their managed care coordinator for follow-up. You can find contact information for managed care organizations in Minnesota at http://www.dhs.state.mn.us/main/id_058986#.

For hospital discharge planners: If the patient is enrolled in a certified health care home, refer to the Health Care Home Care Coordinator. They will work directly with Senior LinkAge Line® to ensure access to Long Term Care Options Counseling and community resources. If you are unaware of whom this is, please refer the patient to the Senior LinkAge Line®.

Please use the following protocol on the next page to have a discussion with patients you believe could benefit from Long Term Care Options Counseling in order to successfully age in place. When making the referral, please identify the reason you are making the referral by checking the appropriate boxes below which are of concern to the patient or caregiver. Please follow your organizational policies for gaining permission from the patient and documenting the permission in the patient's record.

After a discussion with the patient and obtaining permission, please make a referral to the Senior LinkAge Line® by submitting a secure online form via web at www.mnaging.org, faxing a form to 1-877-783-4053 or calling toll free at 1-800-333-2433. If the patient declines the referral, feel free to provide a Senior LinkAge Line® brochure in their discharge packet.

Note: In order to submit this form indicating the patient would benefit from Long Term Care Options Counseling from the Senior LinkAge Line®, the health care provider needs to get permission from the patient to provide their personal data to the Senior LinkAge Line®. Please inform the patient that the Senior LinkAge Line® is concerned about the security and privacy of personal information in its possession; therefore it takes reasonable and legally mandated state and federal precautions to safeguard and secure the information from loss, misuse, unauthorized access, disclosure, alteration, and destruction.

By submitting this information, I, as a health care provider confirm that I have received permission from the patient to collect personal information for the Senior LinkAge Line® and submit the information via this online form. I certify that the information included in this submission is true and complete to the best of my knowledge, without omission of any consequence.