OAK SIDE HAVEN
RESIDENTIAL SENIOR LIVING
A DIVISION OF
With Open Arms RESIDENTIAL CARE

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PEOPLE • PURPOSE • A BRIGHTER TOMORROW

- Home
- Community
- Compassion
- Belonging

REFERRAL INTEREST FORM

A SMALLER SETTING. MORE PERSONAL CARE.

SERVING LAKE & PORTER COUNTIES

Thank you for considering With Open Arms Residential Care.
Together, we create brighter tomorrows.

1. INDIVIDUAL INFORMATION

Full Name: _____
Date of Birth: ____/____/____ Age: _____
Gender: ☐ Male ☐ Female ☐ Other
Phone Number: _____
Email (if available): _____
Address: _____
City: _____ State: _____ ZIP: _____

2. TYPE OF SERVICES INTERESTED IN (*Check all that apply*)

Residential Senior Living (Oak Side Haven)

- ☐ Private-Pay Residential Living
- ☐ Assisted Living
- ☐ Respite (if available)
- ☐ Short-Term Stay
- ☐ Long-Term Stay

Medicaid & Community-Based Services (With Open Arms)

- ☐ Personal Care / Attendant Care
- ☐ Home & Community Assistance
- ☐ Transportation
- ☐ Community Integration & Outings
- ☐ Daily Living Support
- ☐ Other: _____

3. CURRENT LIVING SITUATION

- ☐ Living alone ☐ With family ☐ With caregiver
- ☐ Assisted living ☐ Nursing facility ☐ Hospital
- ☐ Other: _____

4. REASON FOR REFERRAL (*Check all that apply*)

- ☐ Seeking residential placement
- ☐ Seeking in-home /community services
- ☐ Seeking companionship/support
- ☐ Current living situation no longer appropriate
- ☐ Transitioning from hospital or facility
- ☐ Other: _____

5. ASSISTANCE NEEDED (*Check all that apply*)

- ☐ Personal care (bathing, grooming, dressing)
- ☐ Medication reminders
- ☐ Meal preparation
- ☐ Housekeeping & laundry
- ☐ Transportation (medical, errands, community)
- ☐ Community outings & social activities
- ☐ Companionship
- ☐ Mobility assistance
- ☐ Safety supervision
- ☐ Home & community planning
- ☐ Daily living support
- ☐ Other: _____

6. MOBILITY & MEDICAL NEEDS

Mobility Status:

- ☐ Independent ☐ Uses cane ☐ Uses walker
- ☐ Wheelchair ☐ Bedbound ☐ Other: _____

Medical Conditions (optional):

_____
_____
_____

7. BEHAVIORAL / COGNITIVE INFORMATION

- ☐ No significant concerns
- ☐ Memory issues (e.g., dementia, Alzheimer's)
- ☐ Wandering risk
- ☐ History of aggression (please explain): _____
- ☐ Other concerns: _____

8. PAYMENT SOURCE (*Check all that apply*)

- ☐ Private Pay
- ☐ Medicaid Waiver (select if applicable):
  - ☐ Health & Wellness (HW)
  - ☐ Traumatic Brain Injury (TBI)
  - ☐ PathWays for Aging
  - ☐ Other: _____
- ☐ Veteran Benefits ☐ Long-Term Care Insurance

9. REFERRAL SOURCE INFORMATION

Name: _____
Title: _____
Agency/Organization: _____
Phone Number: _____
Email: _____
Preferred Method of Follow-Up: ☐ Phone ☐ Email

10. ADDITIONAL INFORMATION

_____
_____
_____
_____
_____

Let's Talk!
219-718-6534

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People • Purpose
A Brighter Tomorrow