CITY OF LONG BEACH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

SENIOR LINKS PROGRAM

Referral

IN THE SPACES BELOW, PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE

REFERRAL DATE:_____

NAME (S) _____ RECEIVED DATE:_____

DOB:_____ AGE:_____ SEX: _____ SOC. SEC. #_____

MEDI-CAL: #_____ MEDICARE: #_____

PRIMARY LANGUAGE SPOKEN IN HOME: _____

PHONE #: _____ MESSAGE PHONE #: _____

ADDRESS: _____

EMERGENCY CONTACT NAME:_____ PHONE #_____

REFERRED BY: _____ PHONE #: _____
(NAME & AGENCY)

[ ] CHECK HERE IF YOU WOULD LIKE TO BE CONTACTED REGARDING THIS REFERRAL

THIS FAMILY/INDIVIDUAL HAS ALSO BEEN REFERRED TO:
(e.g. ADULT PROTECTIVE SERVICES, ENVIRONMENTAL HEALTH, Senior Police etc.)

AGENCY: _____ CONTACT PERSON: _____ PHONE #: _____

AGENCY: _____ CONTACT PERSON: _____ PHONE #: _____

REASON FOR REFERRAL:
(ATTACH ADDITIONAL PAGE IF NECESSARY)

SEND THIS REFERRAL TO: HealthyAgingCenter@longbeach.gov **OR FAX TO: (562) 570-1002**
IF ANY QUESTIONS PLEASE CALL (562) 570-3555