

**LEL Home Services, LLC****Form CRF001**

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**CUSTOMER REFERRAL FORM**

Please send us the completed information below via mail, fax or email.

Today's Date

**Customer Information**

Customer Last Name	Birth Date	Medicaid #	Social Security Number
Customer First Name	Customer Middle Initial	Medicare #	Gender: Male ____ Female ____
Customer Address	Customer Phone Number	Waiver Type	Legal Status
Customer City	Customer State	Level of Disability	
Is there an existing Notice of Action? Yes ____ No ____ Date: ____ / ____ / ____	Customer ZIP	Services Needed	
		Services Needed by When?	

**Primary Contact Information**

Primary Contact Last Name	Primary Contact Phone Number		
Primary Contact First Name	Primary Contact Alternate Phone Number		
Primary Contact Address	Primary Contact Email Address		
Primary Contact City	Primary Contact State	Does the customer have potential consultants (caregiver to assist him / her)? Yes__ No __*	
Relationship to Customer (ie. father, sister, etc).	Primary Contact ZIP	* LEL normally does not locate or match customers with caregivers.	

**Case Manager Information**

Case Manager Last Name	Case Manager Phone Number		
Case Manager First Name	Case Manager Alternate Phone Number		
Case Manager Company Name	Case Manager Email Address		
Case Manager Address			
Case Manager City	Case Manager State		

<u>Office Use Only</u>	Revision	6
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