alzheimer's association®

Alzheimer's Association, Washington State Chapter
Serving Washington State & Northern Idaho

Programs and Services Referral Form

Please complete all information below.
Return completed form by fax: (206) 363-5700; or email:
helplinewa@alz.org

Date:_____
Referred by:_____ Title/Role:_____
Phone #:_____Organization:_____
Email: _____

TCARE ID (if applicable): _____
Is Care Receiver accessing Medicaid Long-term Services & Supports?: ☐ Yes ☐ No ☐ Unknown
Does Care Receiver live in an ALF, SNF, AFH, other supportive setting?: ☐ Yes ☐ No ☐ Unknown

Referring individual/family to:

Connections Care Consultation Program ☐ EI Portal Program ☐
Early Stage Memory Loss Programs ☐ Support Groups ☐

Individual with Memory Loss or Dementia:

Name:_____Date of Birth: _____
Address:_____
City:_____County:_____Zip Code: _____
Telephone:_____Living Arrangement: _____

Primary Caregiver

Name:_____Date of Birth: _____
Address:_____
City:_____County:_____ Zip Code: _____
Telephone:_____Email Address: _____

Caregiver aware they will be contacted by the Alzheimer's Association? Yes ☐ No ☐
May we leave a voicemail identifying the Alzheimer's Association? Yes ☐ No ☐

Any additional contact considerations? _____

Notes:

Please note that referrals are typically processed within 5-7 business days.

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