

Referral Form: CAPABLE Program



How to Submit a Referral?

Please complete the form below and return via email or fax.

Email: CAPABLE@Schofieldcare.org Fax: 716-657-6901



CAPABLE

Referring Person/Organizaton Information

Name of Contact Person:

Phone:

Name of Organization:

Email:

Participant Being Referred

Name of Participant Being Referred:

Participant Date of Birth:

Participant Phone:

Participant Email:

Participant Address:

Anticipated Discharge Date (if applicable):

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Comments About This Referral:

CAPABLE Program Eligibility Screening

Is the individual age 60 or older? ☐ Yes ☐ No

Is the individual cognitively intact or mildly impaired and willing to participate in goal setting? ☐ Yes ☐ No

Does the individual have difficulty with at least one ADL or two or more IADLs? ☐ Yes ☐ No

Is the individual Medicaid eligible OR below 150% of the Federal Poverty Level? ☐ Yes ☐ No

Is the individual NOT receiving duplicative paid services similar to CAPABLE? ☐ Yes ☐ No

All responses must be "Yes" to proceed with referral

For more information, please call us at 716.874.2600, ext. 6425 or by email: CAPABLE@Schofieldcare.org