Silver Lining Solutions, Inc.
Your Medicaid Application Professionals

# MEDICAID LONG TERM CARE REFERRAL

Date: Assigned Case Manager:

Facility: Facility Contact Name and #:

**CLIENT INFORMATION:**

Applicant's Name:

Birth Date: Social Security #

Gender: Male Female Marital Status: Single Married Divorced Widow

Admit Date: Medicaid Start Date:

Name of Responsible Party:

Relationship:

Address:

Home Telephone #:

Cell Phone #:

Work Phone #:

Email Address:

Additional Notes:

***Please submit this form to:*** **FAX #: 978-887-1144 or EMAIL: info@silverliningsolutionsma.com**

**461 Boston Street, Unit B1**
**Topsfield, MA 01983**
**Office: 978-887-1100**
**Cell # 978-807-7791**

**Website: www.silverliningsolutions.com**

For SLS Administration:

- ☐ Invoice
- ☐ Client Fee Agreement
- ☐ Report Database