Hughes Memorial

Please complete print and complete the applicant information and the Physician information and either scan document and email it to hughesmemorial57@gmail.com or mail it to 10 SHORTY LN, ROCHESTER, PA. 15074

Applicant Information

Name *(first, middle, last)*:_____

Recipient ID Number *(Medicaid recipients only)*:_____

Date of birth *(mm/dd/yyyy)*:_____

Social Security Number:_____

Street address:_____
City: Zip Code:_____

Email address:_____

Phone number:_____

Alternate phone: _____

⇪ Please correspond with the additional contact(s) below to begin process, rather than the applicant. **Note:** Applicant or legal representative **must sign** consent below.

Additional Contacts *(add another page, if needed)*

Contact name or entity:_____

Contact type: ☐ Family ☐ POA ☐ AAA ☐

Social Worker Phone number:_____

Signature of applicant authorizing sharing of information with this contact:

_____

Referral Made By

Name:_____

Agency:_____

Date of referral *(mm/dd/yyyy)*:_____

Phone number:_____

Email address:_____

*Signature:*_____

☐ Above staff has confirmed that the referral has requested that an application be initiated on their behalf. *(Check box to confirm.)*

Physician Information

Physician name:_____

Physician street address:_____
City: Zip Code:_____