



**HEALTHY AGING CENTER (HAC)**  
Referral Form

**Department of Health & Human Services**  
Healthy Aging Center (HAC) - *Senior Links*  
1150 E 4th Street - Room 111, LB, CA 90802  
HealthyAgingCenter@longbeach.gov  
ph: 562-570-3529

Primary Contact Information:			
FIRST AND LAST NAME:			DATE OF BIRTH:
ADDRESS:		CITY:	ZIP:
PHONE:	EMAIL:		
ETHNICITY:	LANGUAGE:	MEDI-CAL: YES      NO	INCOME (monthly or yearly): \$

Referring Agency:		
AGENCY NAME:		REFERRAL DATE:
CONTACT PERSON:	EMAIL:	PHONE:

Alternative Point of Contact (family member, caregiver, neighbor, friend, etc.):		
FIRST AND LAST NAME:	PHONE:	RELATIONSHIP:
FIRST AND LAST NAME:	PHONE:	RELATIONSHIP:

**REQUESTED SERVICES/AREAS OF NEEDED SUPPORT:**

(PLEASE IDENTIFY ONE OR MORE AREAS OF SUPPORT NEEDED)

- |  |                      |
|--|----------------------|
| <input type="checkbox"/> Physical Health/Health Care | Forms/Applications   |
| <input type="checkbox"/> Caregiving/In-Home Support  | Nutrition Assistance |
| <input type="checkbox"/> Social Services             | Transportation       |
| <input type="checkbox"/> Other: _____                |                      |

**REASON(S) FOR REFERRAL/ADDITIONAL DETAILS:**

IN THE BOX BELOW (OR ON AN ATTACHED DOCUMENT -IF ADDITIONAL SPACE IS NEEDED), PLEASE EXPAND ON ANY IDENTIFIED/OBSERVED NEEDS THE CLIENT MIGHT HAVE.

**FOR QUESTIONS OR CONCERNS:**

Please call the Healthy Aging Center (HAC) at **562-570-3529** or email [HealthyAgingCenter@longbeach.gov](mailto:HealthyAgingCenter@longbeach.gov)

FOR HAC OFFICE USE ONLY		
ASSIGNED STAFF MEMBER:	CHART NUMBER:	DATE:

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