Date: Click or tap to enter a date.

To Our Kupuna Administrative Team:

I am writing on behalf of:

|  |  |
| --- | --- |
| *Client name:* Click or tap here to enter text. | *DOB:* Click or tap to enter a date. |
| *Address:* Click or tap here to enter text. | *Phone number:* Click or tap here to enter text. |
| *Client’s Insurance(s)*: Click or tap here to enter text. |

Served by this referring agent:

|  |  |
| --- | --- |
| *Agency Name:* Click or tap here to enter text. |  *From:* Click or tap to enter a date. until present. |
| *Referring Agent’s Name:* Click or tap here to enter text. |  *Title:* Click or tap here to enter text. |
| *Email address:* Click or tap here to enter text. |  *Phone #:* Click or tap here to enter text. |

Please review the following eligibility requirements for Our Kupuna Services:

* Age 60 or older
* Lives alone; no family/friends who are able to give reliable help every 2 weeks
* No duplicate agency support (not receiving grocery/supply delivery services from elsewhere)
* Inability to order/pay for delivery services, don’t have the means to learn
* Unable to shop for self: Need to avoid exposure to public areas, or has mobility issues
* Not bed-bound (the volunteer will deliver supplies to the door for the kupuna to bring inside themselves)
* Can communicate reliably with their assigned volunteer and with Our Kupuna staff
* Is willing to follow Our Kupuna policies and procedures, can follow and is of sound mind (our volunteers are **volunteers**, not trained mental health professionals)
* Is aware of referral being submitted to Our Kupuna and is interested in participating
* Has regular/periodic check-ins with referring agent, has been assessed within last 90 days.

*Dates that service is requested:* Click or tap here to enter text.

Understanding the above eligibility requirements, please provide a written statement explaining the kupuna’s severity of need, addressing each of the above criteria.

Click or tap here to enter text.

Referring Agent Acknowledgement: Upon reviewing the criteria for eligibility and assessing the above-named client, this referral serves as my endorsement of the client/patient’s need for Our Kupuna’s service. Additionally, I will be open to communication or further engagement with Our Kupuna regarding the client’s future situation/needs. I understand that this referral is subject to review or renewal at Our Kupuna’s discretion.

Sincerely,
Click or tap here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Treating Professional’s Signature*