

### Service Referral and Follow-up Summary

Immediate Need:  Y  N

Staff Name \_\_\_\_\_ Contact/Referral Date \_\_\_\_\_

**Section 1 Client Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ (City) (State) (zip) Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Companion Case: \_\_\_\_\_ DOB: \_\_\_\_\_  New  Active Primary Language \_\_\_\_\_ Translator Needed  Y  N

Referral Source: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

**Section 2 Current Services/Benefits**

IHSS - SW: \_\_\_\_\_  MSSP - SW: \_\_\_\_\_  APS - SW: \_\_\_\_\_  Family Caregiver Support Program  
 HRS: \_\_\_\_\_  Linkages-SW: \_\_\_\_\_  Ombudsman \_\_\_\_\_  Other: \_\_\_\_\_

Client has applied for or receives the following:

SSA - \$ \_\_\_\_\_  Pension - \$ \_\_\_\_\_  Medicare \_\_\_\_\_  Private Ins. \_\_\_\_\_  
 SSI - \$ \_\_\_\_\_  Assets: \_\_\_\_\_  Medi-Cal \_\_\_\_\_  Other: \_\_\_\_\_

**Section 3 Needs Assessment**

**Areas of need or concern:**

Health  Income  Food/Meals  Transportation  Other: \_\_\_\_\_  
 Health Coverage  Housing/Shelters  Legal  Mobility (Bed/WC Bound) \_\_\_\_\_  
 Home Health  Housekeeping  Case Management  Caregiver Resources \_\_\_\_\_  
 Personal Care  DME  Medications  Elder Abuse \_\_\_\_\_

Lives Alone:  Y  N # in Household: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Phone: \_\_\_\_\_

Live-in Caregiver:  Y  N Caregiver Relief:  Y  N Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Summary/Diagnosis/

Recent Hospitalizations: \_\_\_\_\_

Special Needs (Immediate Need) Summary:

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

**Section 4 Referral**

Client referred to the following Aging and Adult Services Programs:

I&A  MSSP  APS  Family Caregiver Support Program  Special Respite  
 IHSS  Linkages  Ombudsman  Community Services Programs  Other: \_\_\_\_\_

Other: \_\_\_\_\_

**Section 5 Follow-up**

Date of Follow-up: \_\_\_\_\_ Contact Person/Respondent: \_\_\_\_\_

Agency/Program able to provide needed service  Agency/Program unable to provide needed service

Mirage Record  No Records Found Case #: \_\_\_\_\_ Status: \_\_\_\_\_

MEDS Record  No Records Found Case #: \_\_\_\_\_ Status: \_\_\_\_\_

Summary: \_\_\_\_\_  
 \_\_\_\_\_

Comments

Needs Met  Yes  No Referral Reviewed By: \_\_\_\_\_ Application Sent \_\_\_\_\_

SW Assignment/SW: _____	Aid Code: _____	Application Date: _____
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