

Instructions for the Downloadable In Home Supportive Services (IHSS) Application

Step 1. Click on the Link to Download the Application.

Step 2. Staff Name, Please Leave Blank, Date, Please Leave Blank.

Please Fill in Sections 1: Name, DOB, SSN, Sex, Address, City, Home Phone.
Client's Primary Language. Referral Source is whoever is sending in application and
contact phone number.

Step 3. Fill in Section 2: Current Services/ Benefits check the boxes that apply. If the Client has
applied for or receives SSA, Pension, please check those applicable boxes. In addition,
amount of income should be included.

Step 4. Fill in Section 3: Needs Assessment, please check all that applies.

Step 5. Complete information about household, caregiver name and phone number, Physician
Name and Phone number.

Step 6. Complete the health summary diagnosis, you may use multiple lines.

Step 7. Check the IHSS box in the Referral Section

Step 8. **PRINT OUT the FORM! This is VERY IMPORTANT, since the forms are not
saveable!**

Please Fax Completed Forms to 209 932-2663

If you have any questions call Information and Assistance

At

209 468-1104

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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