Clear Form

Service Referral and Follow-up Summary

Immediate Need: ☐ Y ☐ N

Staff Name _____ Contact/Referral Date _____

Section 1 Client Information

Name: _____ (Last) _____ (First) 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:

Print Form

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