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: