|  |
| --- |
| MSSP CARE MANAGEMENT REFERRAL FORMPlease email this form to Elder.Help@Ventura.org or fax to 805-477-7312. Filling out this form does not guarantee enrollment but will help us determine which applicants are best suited for MSSP.   |
| MSSP REQUIREMENTS  |
| The Multipurpose Senior Service Program (MSSP) Is a Medi-Cal Funded Program\*. Applicants must:1. Meet 2013 Annual Poverty Level Guidelines – *Single*: $11,490 or less *Married*: $15,510 or less 2. Be Age 65 or over 3. Have Medi-Cal with $0 Share of Cost in Ventura County \*INFO RE: OTHER CARE/CASE MANAGEMENT PROGRAMS CAN BE FOUND AT:**AAA.COUNTYOFVENTURA.ORG** (CLICK “*RESOURCES”* THEN “*PAMPLETS & BROCHURES”*) |
| **REFERRAL SOURCE INFO** |
| Referral Name (i.e. Your Name):        | Today’s Date:       |
| Relationship and/or Agency Affiliation:        | Phone Number:       |
| Is Applicant aware a referral has been made: [ ]  Yes [ ]  No |
| Does Applicant appear open to contacts & willing to collaborate with MSSP staff: [ ]  Yes [ ]  No |
| Comments:       |
| **REASON(S) FOR REFERRAL – MARK ALL APPLICABLE BOXES**  |
| [ ]  Bathing Assistance[ ]  Chores[ ]  Transportation[ ]  Home Repairs | [ ]  Safety Items (ex. Grab Bars)[ ]  ERS (ex. “Lifeline”)[ ]  Caregiver Respite[ ]  Moving Assistance | [ ]  Check-In Calls[ ]  Counseling[ ]  Bill Paying [ ] Other:       |
| **APPLICANT INFORMATION**  |
| Full Name:       | Applicant Phone Number:        |
| Home Address:       |
| City:       | Zip Code:       |
| Date of Birth *(age 65+)*:        | Gender : [ ]  Male [ ]  Female [ ]  Other |
| Marital Status:       | Does Applicant Live Alone: [ ]  Yes [ ]  No  |
| Primary Language\*:       \**If Non-English speaking, can caregiver translate:* [ ]  Yes [ ]  No  | Medi-Cal #:       or Social Security #:       |
| **MARK IF USES** |
| [ ]  Oxygen [ ]  G-tube [ ]  Wheelchair [ ]  Walker [ ]  Cane [ ]  Hearing Aid [ ] Glasses |
| **ACTIVITIES OF DAILY LIVING – MARK BOX IF APPLICANT NEEDS SUBSTANTIAL HELP**  |
| [ ]  Transferring [ ]  Toileting[ ]  Bathing [ ]  Dressing[ ]  Eating  | [ ]  Telephone [ ]  Medications [ ]  Housework [ ]  Laundry [ ]  Transportation | [ ]  Shopping [ ]  Meal Prep [ ]  Bill Paying [ ]  Walking[ ]  Comments:       |
| **HEALTH SYSTEMS – MARK ALL APPLICABLE BOXES** |
| [ ] Chronic Pain[ ] Dementia[ ]  Thyroid[ ] Hearing[ ] Vision[ ] Heart Disease[ ] High Blood Pressure | [ ] Movement Disorder[ ] Pressure Ulcers[ ] Respiratory[ ] Stroke[ ] Cancer[ ] Incontinence[ ] Arthritis | [ ] Depression[ ]  Diabetes[ ] Digestive Problems[ ]  History of Falls[ ]  Speech[ ]  Mental Health Issues[ ] Other:       |

|  |
| --- |
| **ADDITIONAL CONTACT INFO**  |
| Is the applicant able to make their own decisions?  | [ ]  Yes [ ]  No |
|  \**If no,* is therea Conservator, Agent, or Representative Payee in place?  | [ ]  Yes [ ]  No |
|  *\*\*If no*, is theresomeone familiar with the applicant’s situation that can answer any further questions (e.g. neighbor, friend, family member, IHSS caregiver)?  | [ ]  Yes [ ]  No |
| Contact Person Name:       | Relationship:        |
|  Phone Number:       | Comments:       |
| OTHER KNOWN AGENCY INVOLVEMENT  |
| [ ]  OASIS[ ]  IHSS [ ]  APS [ ] Senior Concerns  | [ ] CBAS (formerly known as ADHC)[ ]  Lutheran Social Services[ ]  Behavioral Health Older Adults[ ] Wellness & Caregiver Center  | [ ]  Veteran’s Administration [ ]  Volunteer Caregivers [ ]  Tri-Counties[ ]  Other:       |
| VCAAA STAFF |
| 1st Screening Call Attempt:       2nd Attempt:       3rd Attempt:       |
| Disposition: [ ]  MSSP [ ]  Applicant Declines [ ]  No Response/Moved [ ]  Ineligible |
| Date Requesting Person/Agency Notified:       |
| Comments:       |
| Screener:       Screening Date:       |

#  *07/2013*