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| MSSP CARE MANAGEMENT REFERRAL FORM  Please email this form to [Elder.Help@Ventura.org](mailto: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 PainDementia ThyroidHearingVisionHeart DiseaseHigh Blood Pressure | | Movement DisorderPressure UlcersRespiratoryStrokeCancerIncontinence Arthritis | | | | | Depression DiabetesDigestive Problems History of Falls Speech Mental Health IssuesOther: | |

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| --- | --- | --- | --- | --- |
| **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*