In-Home Supportive Services Application Referral Form

I. CONTACT INFORMATION

1. Are you making this referral for yourself? ☐ Yes (Proceed to #3) ☐ No (Proceed to #2)

2. If you answered "No" above, what is your relationship to the applicant?

☐ Parent ☐ Adult Son ☐ Adult Daughter ☐ Friend ☐ Hospital Discharge Planner

☐ Other, please explain:

Your Name: Telephone Number:

3. Applicant Name:	**4.** Gender: ☐ Male ☐ Female
5. Social Security Number:	**6.** Birthdate:
7. Language/Ethnicity:	**8.** Marital Status:
9. Address:	
10. E-mail Address:	**11.** Telephone Number:

12. Are you related to a Napa County employee? ☐ Yes ☐ No - If yes, who/relationship?

13. Whom should we contact for additional information?

☐ Applicant ☐ Other, please provide name & telephone number:

II. HOUSEHOLD COMPOSITION

14. Does the applicant live alone? ☐ Yes ☐ No (List household members below)

Name/s:	Relationship to Applicant:	Birthdate:

III. DIAGNOSIS/HEALTH PROBLEMS:

15. What is your disabling condition(s) (including mental illness)?

16. Do you expect your disability to last 12 months or more? Yes ☐ No ☐

17. Have you had a fall in the past year? ☐ Yes ☐ No If yes, where & did it result in injury?

18. Have you been to the emergency room or hospitalized in the past year? ☐ Yes ☐ No

If yes, what happened & how long were you there for?

IV. AT RISK OF OUT OF HOME PLACEMENT:

19. Do you need assistance every day? ☐ Yes ☐ No- If no, how many days/week?

20. Is there someone currently helping you? ☐ Yes ☐ No. If yes, who?

21. What type of assistance do you need?

☐ Housecleaning ☐ Meal Preparation ☐ Grocery Shopping ☐ Running Errands ☐ Laundry

☐ Bathing ☐ Dressing ☐ Toileting ☐ Walking ☐ Transfers

☐ Medication Management ☐ Accompaniment to Medical Appointments

☐ Other, please explain:

22. Do you have Medi-Cal? ☐ Yes ☐ No – If no, you will need to apply.

23. Are you blind or visually impaired? ☐ Blind ☐ Visually Impaired ☐ N/A

24. If you are blind or visually impaired, would you like an accommodation? ☐ N/A ☐ No

☐ 18 point font documents ☐ Audio CD ☐ Data CD ☐ County Support

FOR COUNTY USE ONLY

Referral Complete: ☐ Yes ☐ No

Follow-Up Required: ☐ Yes ☐ No

Follow-Up Completed On:

Previously Received IHSS: ☐ Yes ☐ No

SW, County & Date:

Any other services:

- ☐ M on W
- ☐ MSSP
- ☐ Adult Day Service
- ☐ Regional Center
- ☐ Home Health
- ☐ Hospice
- ☐ Other:

End of Life: ☐ Yes ☐ No

Minors Only

2Parent Household: ☐ Yes ☐ No

Employment Status:

Confirmation/Case Number:

Assigned To:

Date Assigned: