COUNTY of VENTURA
Area Agency on Aging

Specialized Case Management for Persons with Alzheimer's Disease or Related Dementia Referral

Please email this form to: LOIS.VCAAA@ventura.org or call with the info: 805-477-7300

Referral Name:		**DATE:**	
Reason for Referral:			

CARE RECEIVER'S INFORMATION

Last Name:		**First Name:** *(No nicknames)*	
Phone:		**Birth Date:** *(Required)*	
Street Address:		**City:**	**ZIP:**
County:		**Rural:** (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State

RACE – Please Choose (X) One:

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hawaiian
☐ Japanese
☐ Korean
☐ Laotian
☐ Multiple Race
☐ Other Asian
☐ Other Pacific Islander
☐ Other Race
☐ Samoan
☐ Vietnamese
☐ White
☐ Decline to State

Ethnicity:

☐ Not Hispanic/ Latino
☐ Hispanic/ Latino
☐ Decline to State

Marital Status:	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Decline to State		
Veteran Status:	☐ Yes ☐ No	**Preferred Language:**	
Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State	**Number of Persons Living in Household:**	

INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):

2-Person Household:
☐ At or below Federal Poverty Level *($16,910/year or less)*
☐ Above Federal Poverty Level *($16,911/year or more)*
☐ Decline to State

1-Person Household:
☐ At or below Federal Poverty Level *($12,490/year or less)*
☐ Above Federal Poverty Level *($12,491/year or more)*
☐ Decline to State

The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAAA values your privacy and you have the option to decline to state.

What was the Care Receiver's sex at birth?	☐ Female ☐ Male ☐ Decline to State
What is the Care Receiver's Gender?	☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Not listed, please specify: _____
How do you describe Care Receiver's sexual orientation or sexual identity?	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Not listed, please specify: _____

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)
Please Check One of the Columns for Each Activity

	TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK ➔	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
ADLS	Eating	☐	☐	☐	☐	☐	☐
ADLS	Dressing	☐	☐	☐	☐	☐	☐
ADLS	Transferring	☐	☐	☐	☐	☐	☐
ADLS	Bathing	☐	☐	☐	☐	☐	☐
ADLS	Toileting	☐	☐	☐	☐	☐	☐
ADLS	Walking	☐	☐	☐	☐	☐	☐
IADLS	Light Housework	☐	☐	☐	☐	☐	☐
IADLS	Shopping/Errands	☐		☐		☐	☐
IADLS	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
IADLS	Transportation	☐	☐	☐		☐	☐
IADLS	Using Telephone	☐	☐	☐		☐	☐
IADLS	Managing Medications	☐	☐	☐	☐	☐	☐
IADLS	Managing Money	☐	☐	☐		☐	☐
IADLS	Heavy Housework	☐	☐	☐	☐	☐	☐

Care Receiver's Cognitive Impairment:	☐ None or Unknown ☐ Mild ☐ Moderate ☐ Severe
Client Q Database/Unique Participant ID Number:	