COUNTY of VENTURA
Area Agency on Aging

MSSP CARE MANAGEMENT REFERRAL FORM

Please email this form to LOIS.VCAAA@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") provides voluntary care management services to low income older adults. The goal of MSSP is to prevent or delay nursing home placement. MSSP is a Medi-Cal Waiver Funded Program with 160 capped client slots in Ventura County; please note there is a waiting list. **ALL APPLICANTS MUST BE:**

1. Age 65+
2. Ventura County Residents
3. Agreeable to regular calls and home visits
4. At risk of nursing home placement due to frail medical conditions and functional limitations
5. Receiving Medi-Cal and meeting U.S. Federal Poverty Level Guidelines *(Example 2020Levels ~ Single: $12,760 or less Married: $17,240 or less)*

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	☐ Safety Items (ex. Grab Bars)	☐ Check-In Calls
☐ Chores	☐ ERS (ex. "Lifeline")	☐ Counseling
☐ Transportation	☐ Caregiver Respite	☐ Bill Paying
☐ Home Repairs	☐ Moving Assistance	☐ 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 #: Medi-Cal Date of Issue: ***Please note, this is required to screen referral***

MARK IF USES

☐ Oxygen ☐ G-tube ☐ Wheelchair ☐ Walker ☐ Cane ☐ Hearing Aid ☐ Glasses

ACTIVITIES OF DAILY LIVING – MARK BOX IF APPLICANT NEEDS SUBSTANTIAL HELP

☐ Transferring	☐ Telephone	☐ Shopping
☐ Toileting	☐ Medications	☐ Meal Prep
☐ Bathing	☐ Housework	☐ Bill Paying
☐ Dressing	☐ Laundry	☐ Walking
☐ Eating	☐ Transportation	☐ Comments:

HEALTH SYSTEMS – MARK ALL APPLICABLE BOXES

☐ Chronic Pain	☐ Movement	☐ Depression
☐ Dementia	☐ Disorder Pressure	☐ Diabetes
☐ Thyroid	☐ Ulcers Respiratory	☐ Digestive Problems
☐ Hearing	☐ Stroke	☐ History of Falls
☐ Vision	☐ Cancer	☐ Speech
☐ Heart Disease	☐ Incontinence	☐ Mental Health Issues
☐ High Blood Pressure	☐ Arthritis	☐ Other:

ADDITIONAL CONTACT INFO

Is the applicant able to make their own decisions?	☐ Yes ☐ No
**If no,* is there a Conservator, Agent, or Representative Payee in place?	☐ Yes ☐ No
***If no*, is there someone familiar with the applicant's situation that can answer anyfurther questions (e.g. neighbor, friend, family member, IHSS caregiver)?	☐ Yes ☐ No

Contact Person Name:	Relationship:
Phone Number:	Comments:

OTHER KNOWN AGENCY INVOLVEMENT

☐ OASIS	☐ CBAS (formerly known as ADHC)	☐ Veteran's
☐ IHSS	☐ Lutheran Social Services	☐ Administration
☐ APS	☐ Behavioral Health Older Adults	☐ Volunteer Caregivers
☐ Senior Concerns	☐ Wellness & Caregiver Center	☐ Tri-Counties

VCAAA STAFF

1st Screening Call Attempt: 2nd Attempt: 3rd Attempt:

Disposition: ☐ MSSP ☐ Applicant Declines ☐ No Response/Moved ☐ Ineligible

Date Requesting Person/Agency Notified:

Screener: Screening Date:

1/2020