MSSP CARE MANAGEMENT REFERRAL FORM

Please 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") 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 with no Share of Cost and meeting U.S. Federal Poverty Level Guidelines *(Example: 201**8** Levels ~ Single: $12,**14**0 or less Married: $16,**46**0 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 ☐ Transgender
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

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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 Disorder	☐ Depression
☐ Dementia	☐ Pressure Ulcers	☐ Diabetes
☐ Thyroid	☐ 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 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	☐ CBAS (formerly known as ADHC)	☐ Veteran's Administration
☐ IHSS	☐ Lutheran Social Services	☐ Volunteer Caregivers
☐ APS	☐ Behavioral Health Older Adults	☐ Tri-Counties
☐ Senior Concerns	☐ Wellness & Caregiver Center	☐ Other:

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:	

9/2017