In-Home Supportive Services Referral Form

SF HSA Department of Disability and Aging Services Program, Fax: (415) 355-2463
Questions? Call: (415) 355-6700, extension 3, or email us at ihss@sfgov.org
Please answer all questions and print clearly

IHSS Applicant

Date Sent: / /

Last Name	**First Name**	**MI**	**Social Security Number** - -	**Birth Date** / /
Street Address	**Apt#**	**Zip**	**Phone** ( ) -	**Email**

What is your gender: (one that best describes your current gender identity)
☐ Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Genderqueer/Gender Non-binary
☐ Not listed. Please specify:

How do you describe your sexual orientation or sexual identity?
(indicate one that best describes your sexual orientation)
☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure
☐ Not listed. Please specify:
☐ Decline to answer

Ethnicity: **Language(s):**

Does applicant receive Supplement Security Income (SSI)? ☐ Yes ☐ No ☐ Unknown

Is the applicant enrolled in Medi-Cal? ☐ Yes ☐ No ☐ Unknown **Interest in CALFRESH?** ☐ Yes ☐ No

If you have Medi-Cal, please indicate Medi-Cal /CIN #:

Does The client consent to IHSS services? ☐ **Yes** ☐ **No**; **If not, please do not proceed with this application.**

Referent Information

Referent Name:	**Relationship to Applicant:**
Phone: ( ) - Ext:	**Agency/Organization:**

Residence/Discharge Information

Living Situation: **Lives Alone?** ☐ Yes ☐ No ☐ Unknown **Number of others in household**:

Household members' relationship to client:
☐ Spouse/Domestic Partner ☐ Adult Child ☐ Other Relative ☐ Non-relative

The client is currently:
☐ At Home/At an Alternative Address
☐ Hospitalized – Target Discharge Date: / /
Was client discharged from facility within the last 30 days? ☐ Yes ☐ No If yes, date: / /

Hospital: Campus/Site: Room: Bed: Floor:

Spouse/Other IHSS Recipient

Is the client married? ☐ Yes ☐ No ☐ Unknown
*If yes, please answer the following questions about the spouse (if in the home).

Last Name	**First Name**	**MI**	**Social Security Number** - -	**Birth Date** / /

Is the spouse an IHSS Recipient? ☐ Yes ☐ No ☐ Unknown
Is the spouse able to do housework? ☐ Yes ☐ No If no, why not?
Spouse's Doctor Information
Name: Address: City: Zip:
Phone: ( ) - Fax: ( ) - Email:

Other IHSS recipients in the household? ☐ Yes ☐ No ☐ Unknown
If yes, IHSS Recipient's Name: Social Security Number: - -
Relation:

On-Call Home Care

Is On-call home care requested? ☐ Yes ☐ No

**Please note: DAAS is unable to authorize On-Call IHSS services without a completed health care certification form SOC 873. Please fax this form to DAAS Intake at (415) 557-5271.*

If yes, why are On-call services needed?

How will service needs be met until IHSS eligibility and services are established?

Applicant's Physician/Clinic Information

Name: Last Name | First Name **Specialty:**

Address: Street Address | City | State | Zip

( ) - Phone Number | ( ) - Fax | Email

Medical and/or Mental Health Information

Diagnosis/Medical Condition (please explain)

Additional Concerns:

Emergency Contact Information

Last Name	First Name	Relation	( ) - Phone Number
Last Name	First Name	Relation	( ) - Phone Number

The following information will help us assess your needs and respond to your request for services. If the form is not completed in full, you will be contacted for more information.

We are unable to authorize emergency on-call home care services without the provision of this information

Functional Ability

	Unknown	Independent	Verbal Assist	Some human help	Lots of human help	Dependent
Eating	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐
Transfer mobility	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐
Ambulating (walking)	☐	☐	☐	☐	☐	☐
Telephone	☐	☐	☐	☐	☐	☐
Mobility indoors	☐	☐	☐	☐	☐	☐
Managing money	☐	☐	☐	☐	☐	☐
Mobility Outdoors	☐	☐	☐	☐	☐	☐
Light housework	☐	☐	☐	☐	☐	☐
Stair climbing	☐	☐	☐	☐	☐	☐
Heavy housework	☐	☐	☐	☐	☐	☐
Managing medicines	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐
Transportation	☐	☐	☐	☐	☐	☐
Meal prep & clean up	☐	☐	☐	☐	☐	☐

Risks

Does the client currently exhibit or have history of…	Active	Not Active	Past History	Unknown	Explain (If Active or Past History)
Violent Behavior	☐	☐	☐	☐	
Financial management/Eviction	☐	☐	☐	☐	

Support System

How are your service needs currently being met? Please be as specific as possible and include information about current caregiver(s) and areas of need.

Other Services

Please list any services you currently receive:

*****Please note that in order to receive IHSS you must be on full-scope Medi-Cal and may still have a share of cost (based on your income). Our staff can assist you in applying for Medi-Cal coverage.*****