

Referral From:

Name: _____
Organization: _____
Services Provided: _____
Email: _____
Phone: _____

For internal use only:

Landlord Agreement? _____
WL/Family Agreement ? _____
Date Faxed to HSS _____

HOME SAFETY MODIFICATION REFERRAL FORM



Please complete as much of this form as possible.

Name of Care Provider: _____

Phone Number of Care Provider _____ Best time to reach? _____

Age of Care Provider _____ Does Care Provider Receive Payment: YES NO

Client's Name: _____ Client Phone: _____

Client's Address: _____

City & Zip _____ Best time to reach client? _____

Date of Birth: _____ Social Security #: _____ Male or Female

Does the Client live alone? *(Please, circle one)* YES or NO

Does the Client Own or Rent their home? *(Please, circle one)* OWN or RENT

Is the Client Medi-Cal Eligible? *(Please, circle one)* YES or NO

Income Level(+/-poverty): _____ Referred to Care Management: YES or NO

Is the Client English speaking? *(Please, circle one)* YES or NO

If no, is there an Interpreter available? *(Please, circle one)* YES or NO

Ethnicity: *(Please, circle one)*

African American, Hispanic, Japanese, Caucasian, Chinese, Vietnamese, Korean, Native Indian,
Other _____

Reason for referral? _____

Has the Client had a fall? *(Please, circle one)* YES or NO

How many falls in the past 6 months? _____

Family Member to contact: _____

Phone Number: _____

What other agencies are involved in clients care? *(ex: Home Health, IHSS, unknown)*

Comments:

*Please FAX your completed form to Gennifer Mountain @ (925)946-1869.
Questions? Call (925) 937-8311 or email gmountain@mowsos.org*

