



Health Projects Center

Dignity and Health for an Aging Population

Online Interest Form for Case Management Programs

Please return all completed forms to: Fax #: 831.459.8138 c/o Intake or HPC Santa Cruz Office c/of Intake 9000 Soquel Ave. Suite 103 Santa Cruz, CA 95062 If you have any questions, please call (800) 624-8304	
Referral Information	
Full Name (First/Last):	
Date of Birth:	Social Security Number:
Marital Status:	
Street Address:	
Contact Number(s):	
Does referral have Medi-Cal? Yes No Do not know:	
Do they have a share of cost for Medi-Cal? Yes No Do not know:	
Medi-Cal Number (required to confirm eligibility):	
Issue Date:	
Enrolled in another type of Case Management Program? Yes* No	
*Name of Program(s):	
Physician Name/Number:	



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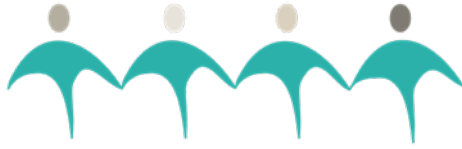
Ethnicity/Cultural Identity:			
Language:			
English Speaker in the Home? Yes* No			
*Name/Number/Relationship:			
Agency Information			
Name of person providing referral information:			
Agency name/contact:			
Would they you an update on the status of the referral? Yes No			
Is the person aware you are making this referral for them? Yes No			
Would you like to be added to the Health Projects Center Email List? Yes No			
Main concerns of agency/social worker for the referral?			
How did you/they find out about The Health Projects Center? Check all that apply.			
Social Media post	Google/Internet Search	HPC In-service or presentation	Friend or Family Member
Social Worker or other Community Agency	Email or TV advertisement	Other (type response)?	
Which of these activities are difficult for you/them to complete?			
Eating	Medications	Meal Prep/Clean Up	
Dressing	Stair Climbing	Transportation	



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Transferring	Walking Indoors	Telephone	
Bathing	Walking Outdoors	Money Management	
Toileting	Laundry	Housework	
Grooming	Shopping/Errands		
Have you/they had any hospitalizations or SNF stays in the past year? Yes No			
Comments:			
Are you/they bed bound, or wheelchair bound? Yes No			
Comments:			
Have you/they had any falls or injuries this past year? Yes No			
Comments:			
Please check the services below where you/they would like to receive more information. (Choose all that apply) *			
Information & Awareness (Adult Community Resources)	Del Mar Caregiver Resource Center (respite grants, education, one on one support)	Care Management Support	In Home Supportive Services (IHSS)
Local Food Pantry or food related resources	Environmental safety needs (ex: ramps, grab bars, etc.)	Emergency Response Button (ERS)	Other:



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What do you/they need help with? (choose all that apply):			
Finding a caregiver	Applying for IHSS	Home Safety Equipment	Managing Finances
Incontinence supplies	Food Resources	Arranging transportation	Legal Advice/ Advanced Directives
Managing Medical Appointments	Socialization/ day care	Respite for family members	Managing Medication
Comments:			
Do you/they have a diagnosis of AIDS or HIV (and therefore <u>may</u> qualify for the MCWP program)?			
	Yes	No	Unknown
Or please contact me to discuss			

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For HPC Internal Use Only:				
<u>Program Eligibility:</u>	MSSP:	ECM:	MCWP:	DM CRC:
SOC? No	Yes	Appropriate MC AID Code?	No?	Yes?
Intake Coordinator Initials and Date: _____				