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: _____ _____