



**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](mailto:ihss@sfgov.org)**  
*Please answer all questions and print clearly*

**IHSS Applicant**

**Date Sent:**    /    /

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Social Security Number</b>	<b>Birth Date</b>
			- -	/ /
			( ) -	
<b>Street Address</b>	<b>Apt#</b>	<b>Zip</b>	<b>Phone</b>	<b>Email</b>
<b>What is your gender:</b> (one that best describes your current gender identity)				
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male <input type="checkbox"/> Trans Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not listed. Please specify:				
<b>How do you describe your sexual orientation or sexual identity?</b>				
(indicate one that best describes your sexual orientation)				
<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed. Please specify: <input type="checkbox"/> Decline to answer				
<b>Ethnicity:</b>		<b>Language(s):</b>		
<b>Does applicant receive Supplement Security Income (SSI)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>Is the applicant enrolled in Medi-Cal?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<b>Interest in CALFRESH?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If you have Medi-Cal, please indicate Medi-Cal /CIN #:</b>				
<b>Does The client consent to IHSS services?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No; If not, please do not proceed with this application.				

**Referent Information**

<b>Referent Name:</b>	<b>Relationship to Applicant:</b>
<b>Phone:</b> ( ) - <b>Ext:</b>	<b>Agency/Organization:</b>

**Residence/Discharge Information**

<b>Living Situation: Lives Alone?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Number of others in household:</b>
<b>Household members' relationship to client:</b>	
<input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Adult Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-relative	
<b>The client is currently:</b>	
<input type="checkbox"/> At Home/At an Alternative Address <input type="checkbox"/> Hospitalized – Target Discharge Date:    /    /	
Was client discharged from facility within the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, date:    /    /	
<b>Hospital:</b>	<b>Campus/Site:</b>
<b>Room:</b>	<b>Bed:</b>
<b>Floor:</b>	

**Spouse/Other IHSS Recipient**

<b>Is the client married?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
*If yes, please answer the following questions about the spouse (if in the home).				
<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Social Security Number</b>	<b>Birth Date</b>
			- -	/ /
<b>Is the spouse an IHSS Recipient?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
<b>Is the spouse able to do housework?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, why not?				
<b>Spouse's Doctor Information</b>				
<b>Name:</b>		<b>Address:</b>		<b>City:</b>
<b>Phone:</b> ( ) -		<b>Fax:</b> ( ) -		<b>Zip:</b>
				<b>Email:</b>
<b>Other IHSS recipients in the household?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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**

<b>Name:</b>		<b>Specialty:</b>	
Last Name	First Name		
<b>Address:</b>			
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. (Please select only one option per ability)

\*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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulating (walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal prep & clean up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Risks

Does the client currently exhibit or have history of...	Active	Not Active	Past History	Unknown	Explain (If Active or Past History)
Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financial management/Eviction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

### 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.\*\*\*