In-Home Supportive Services Referral Form

San Francisco Department of Disability and Aging Services

IMPORTANT NOTES:

1) **Please answer all questions and print clearly.**
2) **Applicant's authorization for release of information is required.**
3) **A completed Health Certification Form (SOC 873) is required to complete the IHSS application process. It can be submitted via fax to 415-355-2463 or emailed to ihss@sfgov.org.**
4) **For questions, please call (415) 355-6700 extension 3.**

IHSS Applicant Information

Date Sent:

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

Gender: (Indicate one that best describes applicant's gender identity)
☐ Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Genderqueer/Gender Non-binary
☐ Not listed. Please specify:

Sexual orientation or Sexual Identity: (Indicate one that best describes applicant's 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 Supplemental Security Income (SSI)? ☐ Yes ☐ No ☐ Unknown

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

If applicant has Medi-Cal, please indicate Medi-Cal /CIN #:

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

Does applicant have the ability to get the required Health Certification Form (SOC873) certified by a health care professional? ☐ **Yes** ☐ **No**

Referent Information

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

Residence/Discharge Information

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

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

The applicant is currently:
☐ At Home/At an Alternative Address
☐ Hospitalized – Target Discharge Date:
Was applicant 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 applicant 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

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

Back Up Provider Services (BUPS)

Is BUPS (emergency home care) requested? ☐ Yes ☐ No
**Please note: DAS is unable to authorize emergency home care services without a completed Health Care Certification form SOC 873. Please fax the SOC 873 to DAS Intake at (415)355-2463.*
If yes, why is emergency home care needed?

How will applicant's needs be met until IHSS eligibility and services are established?

Physician/Clinic Information

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

Address: **Street Address** **City** **State** **Zip**

Phone Number **Fax** **Email**

Medical and Mental Health Information

Please list diagnosis/medical condition

Additional Concerns

Emergency Contact Information

Last Name	First Name	Relationship	Phone Number
Last Name	First Name	Relationship	Phone Number

Risks

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

Other Circumstances

	Yes	No	Unknown	Explain (If answer is YES)
Is applicant at risk of abuse or have a history of being abused?	☐	☐	☐	
Does applicant currently have or have history of suicidal ideation?	☐	☐	☐	
Please indicate any potential dangers to the worker visiting the applicant (e.g. aggressive pet, weapons, property hazards, potentially abusive person on site, etc.)				

Support System

How are the applicant's 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 other services the applicant is currently receiving.

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