



**VENTURA COUNTY AREA AGENCY ON AGING  
ELDERHELP PROGRAM (EHP) REFERRAL FORM FY 2017-2018**

Please email this form to: [Elder.Help@ventura.org](mailto:Elder.Help@ventura.org) or call with the info: 805-477-7300

(One Form per Individual)

Requesting Agency:		Today's Date:	
Requestor:		Phone Number:	
Client informed of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address:	
<b>PLEASE SELECT ONE EHP SERVICE</b>			
1. <input type="checkbox"/> <b>Personal Care</b> ( <i>Bathing</i> )	2. <input type="checkbox"/> <b>Homemaker</b> ( <i>Light Cleaning</i> )	3. <input type="checkbox"/> <b>Chore</b> ( <i>Deep Cleaning</i> )	
4. <input type="checkbox"/> <b>Minor Residential Home Repair/Modification and/or Personal Security Devices</b>			
<ul style="list-style-type: none"> <li>• What is needed? _____</li> <li>• Does client own their home? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li style="padding-left: 20px;">If "no", has landlord been contacted re: these needs? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>			
5. <input type="checkbox"/> <b>Emergency Food Box</b> ( <i>one-time-only shelf stable, nutritious food staples</i> )			
<ul style="list-style-type: none"> <li>• Describe situation &amp; why a food box is needed: _____</li> <li>• Weeks of food needed: <input type="checkbox"/> One <input type="checkbox"/> Two</li> <li>• Dietary Restrictions: _____</li> <li>• Plan for Pickup: _____ Additional Comments: _____</li> </ul>			
6. <input type="checkbox"/> <b>Senior Life Boat - Emergency Aid Vouchers</b> ( <i>one-time-only assistance to address urgent food, shelter or warmth related need; past vouchers included: utilities payment, rental deposit, heater repair, moving assistance, etc.</i> )			
<ul style="list-style-type: none"> <li>• Describe situation &amp; specific assistance needed: _____</li> <li>• Can your agency share in the cost? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Have other agencies been called prior to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>			
<p><b>➔ Referring Agency must check here:</b> <input type="checkbox"/> <i>I am familiar with the client and can certify the need for a Senior Life Boat – Emergency Aid Voucher; if approved, I agree to be the responsible party coordinating voucher assistance.</i></p>			
<b>MARK IF REFERRAL(S) NEEDED TO OTHER VCAAA PROGRAMS</b>			
<i>A VCAAA representative will contact the client and/or caregiver directly; additional eligibility criteria may apply and waiting lists may be in effect for some programs/services.</i>			
<b>➔ Describe specific assistance needed &amp; reason for referral to the program(s) listed below:</b>			
<input type="checkbox"/> <b>I &amp; A</b> <i>Information and Assistance links callers to specific services, provides advocacy and follow-up</i>			
<input type="checkbox"/> <b>HICAP</b> <i>Health Insurance Counseling and Advocacy Program provides free and objective information and counseling about Medicare; is a Covered California partner agency, assisting Californians w/ obtaining health insurance; HICAP also offers a benefits enrollment center.</i>			
<input type="checkbox"/> <b>Senior Nutrition Program</b> <i>Congregate Meals (served in a community or senior center for fairly mobile seniors, encourages socialization), Home-Delivered Meals (for homebound seniors due to illness, function, or disability), and nutrition counseling/education for seniors age 60+</i>			
<input type="checkbox"/> <b>HomeShare Program</b> <i>Matches home owners (usually seniors), with home seekers (usually younger adults)</i>			
<input type="checkbox"/> <b>MSSP</b> <i>Multipurpose Senior Services Program provides ongoing care management for low income seniors age 65+</i>			
<b>MARK ONE BOX BEST DESCRIBING OVERALL SITUATION</b>			
<input type="checkbox"/> <b>Relatively Stable</b> <i>has some family support</i>	<input type="checkbox"/> <b>Early Deteriorating</b> <i>Self-determined, aware of risks</i>	<input type="checkbox"/> <b>Actual/Potential Crisis</b> <i>recent hospital discharge and/or lives alone</i>	
<b>CAREGIVER INFO (IF APPLICABLE)</b>			
Caregiver/Alternate Contact Name:			
Phone Number for Caregiver/Alternate Contact:			
Caregiver Comments: _____			

**REQUIRED INFO ABOUT THE CLIENT**

Client Name: \_\_\_\_\_ Phone Number of Client: \_\_\_\_\_

Street Address Where Care Is To Be Provided From: \_\_\_\_\_

City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: *(must be age 60+)* \_\_\_\_\_ Primary Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Gender:  Male  Female  Transgender Man  Transgender Woman  Declined to State

Does client live alone?  Yes  No  
 Does client have hoarding issues?  Yes  No  
 Any known firearms, animals, etc.?  Yes  No  
 Additional Comments/Concerns: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Not Hispanic/Latino

Race (Choose One):

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Hawaiian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Japanese	<input type="checkbox"/> OTHER RACE <i>(Includes Hispanic/Latino)</i>
<input type="checkbox"/> Cambodian	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan
<input type="checkbox"/> Chinese	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Filipino	<input type="checkbox"/> Multiple Race	<input type="checkbox"/> White <input type="checkbox"/> Declined to State

Daily Activities – Help Is Needed:	Independent, Needs No Help	Verbal Cueing Required	Standby Assist Required	Hands On Assist Required	Dependent On Others For Task
Eating/Feeding Self	<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"/>
Transferring	<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"/>
Toileting	<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"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing Meals	<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"/>
Managing Medicines	<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"/>
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Heavy Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing Light Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using Avail Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**VCAAA USE ONLY**

Date EHP Referral Received: \_\_\_\_\_ Comments: \_\_\_\_\_

Approved:  Yes  No Date Requesting Agency Contacted: \_\_\_\_\_

Approved EHP Service:  Personal Care  Homemaker  Chore  Food Box  Grocery Voucher  Home Mod &/or Sec Devices (Ownership: \_\_\_\_\_)  Other: \_\_\_\_\_

Units approved: \_\_\_\_\_ Service Date(s) Approved: \_\_\_\_\_

Price per Unit: \_\_\_\_\_ Vendor Selected: \_\_\_\_\_

Date Forwarded Other VCAAA Programs (if applicable):  I&A  HICAP  SNP  MSSP  
 HomeShare  Other: \_\_\_\_\_ Comments: \_\_\_\_\_

07/2017