Referral From:

Name:_____
Organization:_____
Email:_____
Phone:_____
Date submitted:_____

For internal use only:

Initial call date_____
2nd call attempt_____
3rd call attempt_____
Sent to Care Management_____
Notes_____
Fund_____

HOME SAFETY MODIFICATION REFERRAL FORM

Client Information

Please complete as much of this form as possible and fax to Meals on Wheels and Senior Outreach Services at 925-946-1869 or email to abalke@mowsos.org.

Client's Name:_____ Client Phone:_____

Care Giver's Name: _____Care Giver's Phone:_____

Client's Address: _____

City & Zip_____ Best time to reach client? _____

Date of Birth: _____ Male or Female Marital Status: _____

Does the Client live alone? YES or NO
Does the Client Own or Rent their home? OWN or RENT Are there any pets in the home? YES or NO
Monthly Income: _____ Referred to Care Management: YES or NO
Insurance type: Medi-care Medi-Cal Insurance company name_____
Does the Client receive CalFresh support? YES or NO
Is the Client English speaking? YES or NO If no, is there an Interpreter available? YES or NO
Race/Ethnicity*: (Please, circle one*)
African American, Asian, Pacific Islander, Hispanic, White, American Indian/Alaska Native, Other_____
Is the Client a Veteran? YES or NO

Reason for referral? _____
Are there any medical conditions we should know about?_____
Has the Client had a fall? YES or NO
If yes, when and where?_____
How many falls in the past 6 months?_____
Was 911 called after fall? Yes or No
Did the call result in ambulance ride/hospital admission Yes or No
In general, how would you rate your overall mental or emotional health? *Answer choices:*
Excellent Very good Good Fair Poor
Is client exercising? YES or NO
Duration & frequency of exercise_____ Interest in an In-Home Exercise Program? YES or NO

Family Member to contact:_____ Phone Number:_____
What other agencies are involved in clients care? *(ex: Home Health, IHSS, unknown)*
Other fall prevention programs available to client: YES or NO

Comments or Referral to Other Program: