



Older Adults, Healthy Results REFERRAL FORM

**Please fax all referrals to our
Pre-Eligibility Unit at 510-383-5060
For questions, please call 510-208-5946**

Older Adults, Healthy Results is a home-visiting, public health nurse case management program that works with clients who are having trouble managing complex health conditions due to psychosocial challenges.

Eligibility criteria:

- 60 years of age or older
- Medi-Cal eligible
- Medically complex (2+ medical conditions)
- At least one functional impairment
- Have decision-making capacity (or surrogate)
- Agree to accept case management services

We do NOT accept the following referrals:

- Primarily psychiatric or substance abuse needs
- Have a need for urgent or daily intervention
- In need of placement to a higher level of care
- Are at end-stage of disease and need palliative care
- Already receiving comprehensive case management

****Note: There may be a delay between referral and intake. Older Adults, Healthy Results maintains a waitlist.
Referred clients will be contacted when space is available****

Client name:		Phone:
		DOB:
Contact person:		SSN:
Phone:		Preferred language:
Address: _____		
	Street	City State Zip

Problems to be addressed:

Desired goals for RN case management:

Other referrals made/services currently received:

- | | | |
|-------------------------------|--|--|
| <input type="checkbox"/> VA | <input type="checkbox"/> IHSS | <input type="checkbox"/> Non-nurse case management |
| <input type="checkbox"/> APS | <input type="checkbox"/> Regional Center | <input type="checkbox"/> Specialty mental health |
| <input type="checkbox"/> MSSP | <input type="checkbox"/> Home health | <input type="checkbox"/> Other: _____ |

MEDICAL CONDITIONS:	Medical provider:	Phone:
		Fax:
	Insurance:	MediCal managed care plan:
	<input type="checkbox"/> Medi-Cal SOC: \$_____	<input type="checkbox"/> Alameda Alliance for Health
	<input type="checkbox"/> Medi-Cal/Medicare	<input type="checkbox"/> Anthem Blue Cross
Behavioral health condition:	BH Provider:	Fax:
		Phone:

Referrer Name:	Phone:
Affiliation/agency:	Fax:

****REQUIRED: PLEASE INCLUDE A PROBLEM LIST, RECENT CLINIC NOTE OR DISCHARGE SUMMARY, AND LIST OF MEDICATIONS****