COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

MSSP CARE MANAGEMENT REFERRAL FORM

Please email this form to LOIS.VCAAA@ventura.org or fax to 805-477-7312.
Filling out this form does not guarantee enrollment but will help us determine which applicants are best suited for MSSP.

MSSP REQUIREMENTS

The Multipurpose Senior Service Program ("MSSP") provides voluntary care management services to low income older adults. The goal of MSSP is to prevent or delay nursing home placement. MSSP is a Medi-Cal Waiver Funded Program with 160 capped client slots in Ventura County; please note there is a waiting list.

ALL APPLICANTS MUST BE:

1. Age 65+
2. Ventura County Residents
3. Agreeable to regular calls and home visits
4. At risk of nursing home placement due to frail medical conditions and functional limitations
5. Receiving Medi-Cal and meeting U.S. Federal Poverty Level Guidelines
   (Example: 2023 Levels ~ Single: $14,580 or less Married: $19,720 or less)

REFERRAL SOURCE INFO

Referral Name (i.e. Your Name):	Today's Date:
Relationship and/or Agency Affiliation:	Phone Number:

Is Applicant aware a referral has been made: ☐ Yes ☐ No

Does Applicant appear open to contacts & willing to collaborate with MSSP staff: ☐ Yes ☐ No

Comments:

REASON(S) FOR REFERRAL – MARK ALL APPLICABLE BOXES

☐ Bathing Assistance	☐ Safety Items (ex. Grab Bars)	☐ Check-In Calls
☐ Chores	☐ ERS (ex. "Lifeline")	☐ Counseling
☐ Transportation	☐ Caregiver Respite	☐ Bill Paying
☐ Home Repairs	☐ Moving Assistance	☐ Other:

APPLICANT INFORMATION

Full Name:	Applicant Phone Number:
Home Address:	
City:	Zip Code:
Date of Birth *(age 65+)*:	Gender: ☐ Male ☐ Female ☐ Other
Marital Status:	Does Applicant Live Alone: ☐ Yes ☐ No
Primary Language*: **If Non-English speaking, can caregiver translate:* ☐ Yes ☐ No	Medi-Cal # or Social Security #: Medi-Cal Date of Issue: ***Please note, this is required to screen referral***

VETERAN STATUS

☐ **I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans' benefits for which I may be eligible. I understand that this consent is valid for 12 months.**

Have you ever served in the United States military? ☐ Yes ☐ No ☐ Decline to State ☐ Missing

Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? ☐ Yes ☐ No ☐ Decline to State ☐ Missing

Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and supports at www.calvet.ca.gov or 1-800-952-5626.

MARK IF USES

☐ Oxygen ☐ G-tube ☐ Wheelchair ☐ Walker ☐ Cane ☐ Hearing Aid ☐ Glasses

ACTIVITIES OF DAILY LIVING – MARK BOX IF APPLICANT NEEDS SUBSTANTIAL HELP

☐ Transferring	☐ Telephone	☐ Transportation	☐ Bill Paying
☐ Toileting	☐ Medications	☐ Shopping	☐ Walking
☐ Bathing	☐ Housework	☐ Meal Prep	☐ Comments:
☐ Dressing	☐ Laundry	☐ Eating	

HEALTH SYSTEMS – MARK ALL APPLICABLE BOXES

☐ Chronic Pain	☐ High Blood Pressure	☐ Incontinence	☐ Speech
☐ Dementia	☐ Movement Disorder	☐ Arthritis	☐ Mental Health Issues
☐ Thyroid	☐ Pressure Ulcers	☐ Depression	☐ Other:
☐ Hearing	☐ Respiratory	☐ Diabetes	
☐ Vision	☐ Stroke	☐ Digestive Problems	
☐ Heart Disease	☐ Cancer	☐ History of Falls	

ADDITIONAL CONTACT INFO

Is the applicant able to make their own decisions?	☐ Yes	☐ No
*_If no,_ is there a Conservator, Agent, or Representative Payee in place?	☐ Yes	☐ No
**_If no_, is there someone familiar with the applicant's situation that can answer any further questions (e.g. neighbor, friend, family member, IHSS caregiver)?	☐ Yes	☐ No

Contact Person Name:	Relationship:
Phone Number:	Comments:

OTHER KNOWN AGENCY INVOLVEMENT

☐ OASIS	☐ CBAS (formerly known as ADHC)	☐ Veteran's Administration
☐ IHSS	☐ Lutheran Social Services	☐ Volunteer Caregivers
☐ APS	☐ Behavioral Health Older Adults	☐ Tri-Counties
☐ Senior Concerns	☐ Wellness & Caregiver Center	

VCAAA STAFF

1st Screening Call Attempt: ☐ 2nd Attempt: ☐ 3rd Attempt:

Disposition: ☐ MSSP ☐ Applicant Declines ☐ No Response/Moved ☐ Ineligible

Date Requesting Person/Agency Notified:

Screener: Screening Date: