Health Projects Center

Dignity and Health for an Aging Population

Online Interest Form for Case Management Programs

Please return all completed forms to:

Fax #: 831.459.8138 c/o Intake or

HPC Santa Cruz Office
c/of Intake
9000 Soquel Ave. Suite 103
Santa Cruz, CA 95062

If you have any questions, please call (800) 624-8304

Referral Information

Full Name (First/Last):

Date of Birth: Social Security Number:

Marital Status:

Street Address:

Contact Number(s):

Does referral have Medi-Cal? **Yes** ☐ **No** ☐ **Do not know:** ☐

Do they have a share of cost for Medi-Cal? **Yes** ☐ **No** ☐ **Do not know:** ☐

Medi-Cal Number **(required to confirm eligibility):**

Issue Date:

Enrolled in another type of Case Management Program? **Yes*** ☐ **No** ☐

*Name of Program(s):

Physician Name/Number:

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Ethnicity/Cultural Identity:

Language:

English Speaker in the Home? **Yes*** ☐ **No** ☐

*Name/Number/Relationship:

Agency Information

Name of person providing referral information:

Agency name/contact:

Would they you an update on the status of the referral?
Yes ☐ **No** ☐

Is the person aware you are making this referral for them?
Yes ☐ **No** ☐

Would you like to be added to the Health Projects Center Email List?
Yes ☐ **No** ☐

Main concerns of agency/social worker for the referral?

How did you/they find out about The Health Projects Center? Check all that apply.

Social Media post ☐	Google/Internet Search ☐	HPC In-service or presentation ☐	Friend or Family Member ☐
Social Worker or other Community Agency ☐	Email or TV advertisement ☐	Other?	

Which of these activities are difficult for you/them to complete?

Eating ☐	Medications ☐	Meal Prep/Clean Up ☐
Dressing ☐	Stair Climbing ☐	Transportation ☐

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Transferring ☐	Walking Indoors ☐	Telephone ☐
Bathing ☐	Walking Outdoors ☐	Money Management ☐
Toileting ☐	Laundry ☐	Housework ☐
Grooming ☐	Shopping/Errands ☐	☐

Have you/they had any hospitalizations or SNF stays in the past year? Yes ☐ No ☐

Comments:

Are you/they bed bound or wheelchair bound? Yes ☐ No ☐

Comments:

Have you/they had any falls or injuries this past year? Yes ☐ No ☐

Comments:

Please check the services below where you/they would like to receive more information. (Choose all that apply) *

Information & Awareness (Adult Community Resources) ☐	Del Mar Caregiver Resource Center (respite grants, education, one on one support) ☐	Care Management Support ☐	In Home Supportive Services (IHSS) ☐
Local Food Pantry or food related resources ☐	Environmental safety needs (ex: ramps, grab bars, etc.) ☐	Emergency Response Button (ERS) ☐	Other:

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What do you/they need help with? (check all that apply):			
Finding a caregiver ☐	Applying for IHSS ☐	Home Safety Equipment ☐	Managing Finances ☐
Incontinence supplies ☐	Food Resources ☐	Arranging transportation ☐	Legal Advice/ Advanced Directives ☐
Managing Medical Appointments ☐	Socialization/ day care ☐	Respite for family members ☐	Managing Medication ☐
Comments:			

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For HPC Internal Use Only:

Program Eligibility: MSSP: ☐ ECM: ☐ MCWP: ☐ DM CRC: ☐

SOC? No ☐ Yes ☐ Appropriate MC AID Code? No? ☐ Yes? ☐

Intake Coordinator Initials and Date: _____ _____