Instructions for the Downloadable
Service Referral and Follow-up Summary (SJ 30A)

Step1.Click on the Link to Download the Referral.

Please Leave Staff Name and Date blank.

Step 2. **Please Complete Section 1**

For the person needing the service (Client):

-Name, DOB (Date of Birth), SSN (Social Security Number), and Sex
-Address and contact Phone number.
-Mailing address if it is different and Client's Primary Language.

Companion Case (anyone in the home already receiving or also applying for services)

Referral Source is the individual assisting with this referral, Relationship = relationship to applicant and referral's phone number.

Step 3. **Fill in Section 2**: Client's Current Services/ Benefits check the boxes that apply.

If the Client has applied for or receives SSA, Pension, please check those applicable boxes. In addition, $ amount of income should be included.

Step 4. **Fill in Section 3:** Needs Assessment, please check all that apply for the client.

Step 5. **Complete information** about: Household, Caregiver name and phone number, Physician Name and Phone number.

Step 6. **Complete the health summary diagnosis**, you may use multiple lines. Include medical diagnosis of the client, include any recent hospitalizations.

Step 7. **In Section 4**: Check the box next to the service you are requesting for the client: for example, IHSS-In Home Supportive Services, APS-Adult Protective Services, etc. Use the "Other" box for other services not listed, for example: MOW-Meals on Wheels.

Leave Section 5 Blank.

Step 8. You may **PRINT OUT** the **FORM** and **FAX** it in by clicking the Print Form Box.

Please Fax Completed Forms to 209 932-2663 or
Mail to: San Joaquin County Human Services Agency, Department of Aging, PO Box 201056 Stockton, CA 95201

If you have any questions call Information and Assistance
At 209 468-1104

Clear Form

Aging and Adult Services Division

San Joaquin County Human Services Agency

Service Referral and Follow-up Summary

Immediate Need: ☐ Y ☐ N

Staff Name _____ Contact/Referral Date _____

Section 1 Client Information

Name: _____ DOB: _____ SSN: _____ Sex: ☐ M ☐ F
(Last) (First)

Address: _____ Phone: _____
(City) (State) (zip)

Mailing Address: _____

☐ Companion Case: _____ DOB: _____ ☐ New ☐ Active Primary Language _____ Translator Needed ☐ Y ☐ N

Referral Source: _____ Relationship _____ Phone: _____

Section 2 Current Services/Benefits

☐ IHSS - SW:	☐ MSSP - SW:	☐ APS - SW:	☐ Family Caregiver Support Program
HRS:	☐ Linkages-SW:	☐ Ombudsman	☐ Other:

Client has applied for or receives the following:

☐ SSA - $	☐ Pension - $	☐ Medicare	☐ Private Ins.
☐ SSI - $	☐ Assets:	☐ Medi-Cal	☐ Other:

Section 3 Needs Assessment

Areas of need or concern:

☐ Health	☐ Income	☐ Food/Meals	☐ Transportation	☐ Other:
☐ Health Coverage	☐ Housing/Shelters	☐ Legal	☐ Mobility (Bed/WC Bound)	
☐ Home Health	☐ Housekeeping	☐ Case Management	☐ Caregiver Resources	
☐ Personal Care	☐ DME	☐ Medications	☐ Elder Abuse	

Lives Alone: ☐ Y ☐ N # in Household: _____ Caregiver: _____ Phone: _____

Live-in Caregiver: ☐ Y ☐ N Caregiver Relief: ☐ Y ☐ N Physician Name: _____ Phone: _____

Health Summary/Diagnosis/
Recent Hospitalizations: _____

Special Needs (Immediate Need) Summary:

_____

_____

_____

_____

Section 4 Referral

Client referred to the following Aging and Adult Services Programs:

☐ I&A	☐ MSSP	☐ APS	☐ Family Caregiver Support Program	☐ Special Respite
☐ IHSS	☐ Linkages	☐ Ombudsman	☐ Community Services Programs	☐ Other:

Other: _____

Section 5 Follow-up

Date of Follow-up: _____ Contact Person/Respondent: _____

☐ Agency/Program able to provide needed service	☐ Agency/Program unable to provide needed service

Mirage Record ☐ No Records Found Case #: _____ Status: _____

MEDS Record ☐ No Records Found Case #: _____ Status: _____

Summary: _____

_____

Comments

Needs Met ☐ Yes ☐ No Referral Reviewed By: _____ Application Sent _____

SW Assignment/SW:	Aid Code:	Application Date: