CalOptima Health

Multipurpose Senior Services Program (MSSP) Referral

Send Referral To:
CalOptima
Attn: MSSP Dept.
Fax: 714-246-8680
Email:
MSSP@caloptima.org

Date _____/_____/_____

Print Your Name_____ **Telephone#**_____ **Email Address:**_____

Agency_____Address_____

Member's Information: Aid Code: _____County Code: _____ DOB ___/___/___ Age____

Member Name_____ Gender: ☐Female ☐ Male
Last **First**

Address _____

+ **city**/zip_____ Telephone/Cell Number(s) _____

Marital Status:☐Mr ☐Wd☐Sep☐Sg☐Dv Ethnicity_____ Speaks English:☐Yes or☐No

Language Spoken_____ **Social Security/ID number** _____

Emergency Contact / Responsible Party _____ Relationship_____
Language Spoken_____

Address _____ Telephone Number_____

Primary Care Physician_____ Telephone Number _____

Diagnoses/History of illness _____
_____
_____

Current Status:

- ❑ Visually impaired
- ❑ Hearing impaired
- ❑ Alert
- ❑ Confused
- ❑ Wheelchair-bound
- ❑ Use a cane or walker
- ❑ Bed-ridden
- ❑ Needs ass't w/eating
- ❑ Needs ass't w/dressing
- ❑ Needs ass't w/transferring
- ❑ Needs ass't w/bathing
- ❑ Needs ass't w/household tasks
- ❑ Needs ass't w/meals
- ❑ Needs ass't w/money management
- ❑ Needs ass't w/transportation
- ❑ **Does the member live alone?**
- ❑ Does the member take 6 or more medications?
- ❑ Does the member receive IHSS hours?
- ❑ Does the member have a regular caregiver
- ❑ **Drives**
- ❑ **Recent falls**

Explain MSSP Needs

_____
_____
_____
_____

Completed by_____ Date_____
For questions, please contact MSSP @ (714) 347-5780.