



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: _____ Ethnicity _____ Speaks English: Yes 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:

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

Explain MSSP Needs:

Completed by _____ Date _____