COUNTY of VENTURA
Human Services Agency
Area Agency on Aging

Specialized Case Management for Persons with Alzheimer's Disease or Related Dementia Referral

Please email this form to LOIS.VCAAA@ventura.org or call with the info: (805) 477-7300

Referral Name:		**Date:**	
Reason for Referral:			

CARE RECEIVER'S INFORMATION

Last Name:		**First Name:** *(No nicknames)*	
Phone:		**Birth Date:** *(Required)*	
Street Address:		**City:**	**ZIP:**
County:		**Rural:** (91307, 93066, 93040)	☐ Yes ☐ No ☐ Decline to State ☐ Missing

RACE – Please Choose (X) One:

☐ American Indian or Alaska Native	☐ Filipino	☐ Laotian	☐ Samoan
☐ Asian Indian	☐ Guamanian	☐ Multiple Race	☐ Vietnamese
☐ Black or African American	☐ Hawaiian	☐ Asian Indian	☐ White
☐ Cambodian	☐ Japanese	☐ Other Asian	☐ Decline to State
☐ Chinese	☐ Korean	☐ Other Pacific Islander	☐ Missing
		☐ Other Race	

Ethnicity:
☐ Not Hispanic/ Latino
☐ Hispanic/ Latino
☐ Decline to State
☐ Missing

MARITAL STATUS: ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (Never Married) ☐ Widowed ☐ Decline to State ☐ Missing

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?
☐ 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?
☐ No
☐ Decline to State
☐ Missing

Preferred Language:

Client Lives:	☐ Alone ☐ Not Alone ☐ Decline to State ☐ Missing	**Number of Persons Living in Household:**	

INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):

2-Person Household:
☐ At or below Federal Poverty Level *($19,720/year or less)*
☐ Above Federal Poverty Level *($19,721/year or more)*
☐ Decline to State

1-Person Household:
☐ At or below Federal Poverty Level *($14,580/year or less)*
☐ Above Federal Poverty Level *($14,581/year or more)*
☐ Decline to State

The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)

The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAAA values your privacy and you have the option to decline to state.

What was the Care Receiver's sex at birth? ☐ Female ☐ Male ☐ Decline to State ☐ Missing

What is the Care Receiver's Gender? ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Decline to State ☐ Missing ☐ Not listed, please specify: _____

How do you describe Care Receiver's sexual orientation or sexual identity? ☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Decline to State ☐ Missing ☐ Not listed, please specify: _____

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CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS) Please Check (✓) One of the Columns for Each Activity							
	TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK ➔	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State
ADLS	Eating	☐	☐	☐	☐	☐	☐
	Dressing	☐	☐	☐	☐	☐	☐
	Transferring	☐	☐	☐	☐	☐	☐
	Bathing	☐	☐	☐	☐	☐	☐
	Toileting	☐	☐	☐	☐	☐	☐
	Walking	☐	☐	☐	☐	☐	☐
IADLS	Light Housework	☐	☐	☐	☐	☐	☐
	Shopping/Errands	☐	☐	☐	☐	☐	☐
	Meal Prep/Cleanup	☐	☐	☐	☐	☐	☐
	Transportation	☐	☐	☐	☐	☐	☐
	Using Telephone	☐	☐	☐	☐	☐	☐
	Managing Medications	☐	☐	☐	☐	☐	☐
	Managing Money	☐	☐	☐	☐	☐	☐
	Heavy Housework	☐	☐	☐	☐	☐	☐
Care Receiver's Cognitive Impairment:		☐ None or Unknown	☐ Mild	☐ Moderate	☐ Severe		

Narrative/Case Notes *(Optional)*:			
Reviewed By:		**Number of Hours:**	
Client Q Database/Unique Participant ID Number:			