Riverside County Office on Aging
Aging & Disability Resource Connection
3610 Central Avenue Suite 102
Riverside CA 92506
rcAging@rivco.org (E-mail)

A life of dignity, well-being, and independence for all older adults and persons with disabilities

Riverside County Office on Aging

Unit Referral Form (U-Form)

FAX to: **(951) 867-3810** **CONFIDENTIAL**

For assistance, call the Office on Aging at **877 - 932 - 4100**

A. CLIENT INFORMATION

☐ CLIENT AGREED TO SERVICES FROM OFFICE ON AGING ON ______

NAME (LAST NAME, FIRST)					DATE OF REFERRAL
TELEPHONE	MOBILE / CELL PHONE	DOB	AGE	PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH OTHER: ______	
RESIDENCE ADDRESS		CITY		ZIP CODE	☐ RURAL AREA
MAILING ADDRESS ***IF DIFFERENT FROM ABOVE***					

GENDER ☐ MALE ☐ FEMALE ☐ Other: ______	☐ VETERAN ☐ DISABLED VETERAN ☐ VETERAN'S SPOUSE	**ETHNICITY**	☐ HISPANIC/LATINO ETHNICITY ☐ NON- HISPANIC/LATINO ETHNICITY

RACE (CHECK ALL THAT APPLY)						
	☐ AMERICAN INDIAN OR ALASKAN NATIVE	☐ CAMBODIAN	☐ FILIPINO	☐ JAPANESE	☐ OTHER PACIFIC ISLANDER	☐ VIETNAMESE
	☐ ASIAN INDIAN	☐ CHINESE	☐ GUAMANIAN	☐ KOREAN	☐ OTHER ASIAN	☐ WHITE
	☐ BLACK OR AFRICAN AMERICAN	☐ DECLINE TO STATE	☐ HAWAIIAN	☐ LAOTIAN	☐ SAMOAN	

Details related to client needs:

B. REQUESTED SERVICES For individuals (or caregivers of) age 60 and older*

☐ **CAREGIVING or HOMEMAKER** ☐ **CASE MANAGEMENT** ☐ **MEALS** ☐ **PURCHASE OF A SERVICE** (e.g., Material Aid)

BENEFIT ASSISTANCE (e.g., IHSS, Cal-Fresh)

TRANSPORTATION (check one) ☐ Bus Pass / Dial-a-Ride (Independent) ☐ Medical or Assisted

OTHER ______

Details related to the service request:

*Carelink and Care Transitions Intervention (CTI) case management programs serve eligible adults ages 18 and older.

REFERRING PARTY INFORMATION PERSON COMPLETING FORM:	TITLE	AGENCY NAME	TELEPHONE

C. SUPPLEMENTAL INFORMATION

Please help make the referral process easier for your clients by providing essential information regarding their benefits.

HOUSING	☐ OWNER	☐ RENTER	☐ HOSPITAL OR FACILITY		☐ HOMELESS SHELTER	☐ SHARED HOUSING (RENT-FREE)		**TOTAL** NUMBER IN HOUSEHOLD
CLIENT LIVES ALONE ☐ = 0	LIVES WITH OTHERS: ADD FOR TOTAL	☐ SPOUSE + 1	☐ ADULT CHILD(REN) + ____	☐ MINOR CHILD(REN) + ____	☐ PARENT / GRANDPARENT + ____	☐ FRIEND / FAMILY ROOMMATE + ____	☐ OTHER + ____	+ ____

INCOME CHECK ALL THAT APPLY	☐ SSA $	☐ SSI $	☐ SDI $	☐ ATD – (AID TOTALLY DISABLED) $	☐ AB – (AID TO THE BLIND) $
	☐ EMPLOYMENT $	☐ RETIREMENT $	☐ PENSION/ ANNUITY $	OTHER Specify: $	

EMPLOYED ☐ Full-Time ☐ Part-Time	☐ RETIRED	☐ PERMANENTLY DISABILITY	☐ UNEMPLOYED	OTHER Specify:

MARITAL STATUS:	☐ DIVORCED	☐ DOMESTIC PARTNER	☐ MARRIED	☐ SEPARATED	☐ SINGLE / NEVER MARRIED	☐ WIDOWED

MEDICARE NUMBER	DATE ISSUED	**MEDI-CAL NUMBER**	DATE ISSUED	**SHARE OF COST** ☐ YES $ ______ ☐ NO ☐ UNKOWN
HEALTH PLAN ______		**HEALTH PLAN** ______		

U-FORM REV. 11/15/2021_mhjlhp