independence at home
A SCAN COMMUNITY SERVICE

INDEPENDENCE AT HOME REFERRAL FORM

Please check-off the program(s) you would like to refer the client to:

☐ Therapy/Conseling (Insights) ☐ T.E.C. Program ☐ Homeless Services (available in Los Angeles, Riverside, & San Bernardino Counties)

☐ Multipurpose Senior Services Program (MSSP) **Applicants for MSSP will be contacted for additional information*

REFERRAL SOURCE

Referral by:		Date:	
Phone:		Email:	
Zip Code:			

How did you hear about our agency? (select one)

☐ Social worker ☐ Family ☐ Friend ☐ Internet/Online Search ☐ IHSS ☐ APS
☐ Indepedence at Home staff ☐ Medical Group/Health Plan ☐ Community Based Organizations
☐ Community Event ☐ RSC ☐ SCAN Newsletter ☐ SCAN Representative ☐ Marketing Meeting

Relationship to applicant (select one):

☐ Self ☐ Social worker ☐ Family ☐ Friend/Neighbor ☐ Caregiver ☐ Care Manager ☐ APS
☐ Indepedence at Home staff ☐ Medical Group/Health Plan ☐ Nurse ☐ Physician's Office
☐ RSC ☐ Other (specify):

Referring Organization (if applicable):

APPLICANT INFORMATION

First Name:		Middle:		Last Name:	
DOB:		Gender:	☐ Male ☐ Female ☐ Transgender ☐ Other not listed ☐ Unknown ☐ Decline to disclose		
Preferred language:	☐ English ☐ Spanish ☐ Other:			Need interpreter? ☐ Y ☐ N	
Race/Ethnicity:	☐ White ☐ Black or African American ☐ Asian or other Pacific Islanders ☐ American Indian or Alaska Native ☐ Hispanic ☐ Two or more races/Other ☐ Unknown ☐ Decline to disclose				
Address:				City:	
State:		Zip:		County:	
Phone:		Mailing Address (if different):			

Is applicant a SCAN Health Plan member? ☐ Y ☐ N

Is applicant a caregiver for someone 55 or over? ☐ Y ☐ N

Does applicant have Medi-Cal? ☐ Y ☐ N *Answer this question for MSSP referrals only.

Does applicant know that a referral is being made? ☐ Y ☐ N *If not, please inform applicant about referral.

ADDITIONAL INFORMATION OF REFERRED APPLICANT: (Please note details/reason for referral)

To Be Completed by IAH staff

Form Completed By:		Screening Date Completed:	
Screening Completed With:		Method of Intake: ☐ Phone ☐ In-person ☐ Fax ☐ E-mail	

Form Updated 08.16.24

Please Email or Fax the Completed Form To

Email: communityoutreach@scanhealthplan.com | **Fax:** (562) 492-9236 | **Phone:** (866) 421-1964