IHSS Referral Form

Date	First Name	Last Name

Physical Address	City	State	Zip
Mailing Address	**City**	**State**	**Zip**

Phone	Social Security #	DOB	Primary Language	Gender

Referred By	Relationship to Prospective Client	Phone Number of Referring Party	Referral Completed By:
☐ Self ☐ Other	☐ Self ☐ Child ☐ Parent ☐ Spouse ☐ Authorized Representative		

List names, ages, and relationship of all people living with you.

Name	DOB	Relationship	Receiving IHSS
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

What is the nature of your disability or illness?

Doctor:

Larger text documents (18pt font) required?: : Yes ☐ No ☐

Medi-Cal: Yes ☐ No ☐ Aid Code:

Any Animals/Hazards in Home?

Additional Information (FNRC, MH, Compass client?):