HOME PROVIDER / AGENCY REFERRAL

PLEASE RETURN REFERRAL TO SHARE Sonoma County via:

- **FAX: 707-766-8899, or**
- **EMAIL: INFO@SHARESONOMACOUNTY.ORG** **DATE UPLOADED TO SF: _____, 2020**

CLIENT CONTACT INFORMATION

Name 1:	
Gender Identity	
Name 2:	
Gender Identity	
Street Address	
City, ST, ZIP Code	
Contact Information	Cell Phone: Email:
Date of Birth Name 1	/ / Place of Birth:
Date of Birth Name 2	/ / Place of Birth:

REFERRAL AGENCY: _____ **CONTACT:** _____

Telephone No.: _____ **Email:** _____

Is your Agency involved with this client on an ongoing basis? ☐ Yes ☐ No

If yes, please describe the services that your Agency is providing for this client*:

_____

_____

_____

***PLEASE HAVE CLIENT COMPLETE RELEASE OF INFORMATION ON THE BACK OF THIS DOCUMENT**

SERVICES YOUR CLIENT(S) CURRENTLY RECEIVES THROUGH SONOMA COUNTY AREA AGENCY ON AGING

☐ APS	☐ LINKAGES	☐ MSSP	☐ IHSS	☐ HCBA Waiver	☐ Veterans Office

CHECK SERVICES REQUIRED

☐ Meal Preparation ☐ Housework ☐ Personal Care	☐ Has IHSS Hours: How Many Hours / Month: _____ ☐ Driving ☐ Gardening ☐ Home Maintenance ☐ Errands / Appointments / Grocery Shopping	☐ Laundry ☐ Pet Care / Walking ☐ Companionship

TRIAGE LEVEL OF CARE (PLEASE SELECT HIGHEST LEVEL OF CARE YOUR CLIENT REQUIRES)

☐ **Level 1**: Needs Rental Income and requires some or no services (may enjoy companionship)
☐ **Level 2**: Housework, Laundry, Pet care: walking, cleaning litter box, picking up after dog
☐ **Level 3**: Driving, Grocery shopping, Meal Preparation, Errands, Excursions
☐ **Level 4**: Daily Morning and Evening Assistance, Errands, Medication Reminders, Medical visits
☐ **Level 5**: Physical assistance, Exercise/Therapies, Transfers and Personal care

Referral Signature	
Date of Referral	

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RELEASE OF INFORMATION

(To be completed if referred client receiving other agency ongoing services)

CLIENT'S NAME: _____ **DOB:** _____

I hereby authorize SHARE Sonoma County, and its representatives, to receive and exchange any medical, employment, social, psychological, educational, and/or service participation records and information regarding myself and my family with any applicable agency and/or service provider in order that SHARE Sonoma County have the ability to collaborate with any and all agencies with whom I am currently receiving services.

This Release of Information is valid until cancelled by written notification by the client.

_____ _____

CLIENT **Date**