



Bay Area Community Services
North County Senior Homeless Program
510-271-8844
FAX 510-451-3110
2116 Broadway Street
Oakland, CA 94612

BACS PARTNER OUTREACH/REFERRAL FORM

The information supplied on this referral form is used to assess the need and eligibility of the Partner for services.

ALL INFORMATION IS CONFIDENTIAL

Date of Referral _____

Date of Partner Contact _____

<p align="center"><u>PARTNER IDENTIFICATION</u></p> <p>Name _____</p> <p>Address/Location _____</p> <p>Phone () _____</p> <p>Date of Birth _____ AGE _____</p> <p>Social Security # _____</p> <p>Sex of Partner ___ Male ___ Female</p> <p align="center"><u>PARTNER'S INCOME</u></p> <p>Total Monthly Income _____</p> <p>Amount and Sources</p> <p>\$ _____ SSA \$ _____ VA</p> <p>\$ _____ SSI \$ _____ Pension</p> <p>\$ _____ Other (specify) _____</p> <p>Total Liquid Assets _____</p> <p align="center"><u>PARTNER RESIDENCE</u></p> <p>Own home _____ Relative's home _____</p> <p>Senior housing _____ Hospital _____</p> <p>Other (specify) _____</p> <p align="center"><u>HOUSING STATUS</u></p> <p>Homeless? How Long? _____</p> <p>at risk of homelessness Explain: _____</p> <p>_____</p> <p>In eviction process – day's left? _____</p> <p>Does the Partner live alone? ___ Yes ___ No</p> <p>If not, how many in household? _____</p> <p>Relationship to Partner _____</p> <p align="center"><u>PARTNER'S COMMUNICATION SKILLS</u></p> <p>Speaks English ___ Well ___ Poorly ___ None</p> <p>Primary language _____</p> <p align="center"><u>CHIEF COMPLAINT/ REQUEST</u></p> <p>_____</p> <p>_____</p> <p>Does Partner need</p> <p>Rep Payee or ___ Bill Payer? _____</p> <p>_____</p>	<p align="center"><u>REFERRAL SOURCE</u></p> <p>Name _____</p> <p>Agency Name _____</p> <p>Phone () _____</p> <p>Fax () _____</p> <p>Relationship _____</p> <p>Does Partner have a case manager/professional contact? ___ Yes ___ No</p> <p>If yes, Name _____</p> <p>Phone _____</p> <p>Agency _____</p> <p>Does Partner have POA or Guardian</p> <p>If yes, Name _____</p> <p align="center"><u>EMERGENCY CONTACT</u></p> <p>Is there a relative or friend who may be contacted in case of an emergency? ___ Yes ___ No</p> <p>Name _____</p> <p>Address _____</p> <p>_____</p> <p>Phone () _____</p> <p>Relationship to Partner _____</p> <p align="center"><u>PARTNER MEDICAL</u></p> <p>Doctor Name _____</p> <p>Phone _____</p> <p>Psych Name _____</p> <p>Phone _____</p> <p>Mental Health Status/Diagnosis _____</p> <p>_____</p> <p>_____</p> <p>Medications (Past/Present)</p> <p>_____</p> <p>_____</p> <p>Physical Health Status/Diagnosis _____</p> <p>_____</p> <p>Medications (Past/Present)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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