RIVERSIDE COUNTY
OFFICE ON AGING
AGING & ABILITY RESOURCE CENTER
(877) 932 - 4100

3610 Central Ave., Ste. 102, Riverside, CA 92506

Unit Referral Form (U-Form)

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

EMAIL to: **rcaging@rivco.org**

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 ☐ ASIAN INDIAN ☐ BLACK OR AFRICAN AMERICAN	☐ CAMBODIAN ☐ CHINESE ☐ DECLINE TO STATE	☐ FILIPINO ☐ GUAMANIAN ☐ HAWAIIAN	☐ JAPANESE ☐ KOREAN ☐ LAOTIAN	☐ OTHER PACIFIC ISLANDER ☐ OTHER ASIAN ☐ SAMOAN	☐ VIETNAMESE ☐ WHITE

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)			
CLIENT LIVES ALONE ☐ = 0	**LIVES WITH OTHERS:** ADD FOR TOTAL	☐ SPOUSE + 1	☐ ADULT CHILD(REN) + _____	☐ MINOR CHILD(REN) + _____	☐ PARENT / GRANDPARENT + _____	☐ FRIEND / FAMILY ROOMMATE + _____	☐ OTHER + _____	**TOTAL** NUMBER IN HOUSEHOLD + _____

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** _____	