



**Older Adults Healthy Results  
REFERRAL FORM**

<https://acphd.org/older-adults-healthy-results/>

Fax referrals to: **510-273-3700** or  
**510-383-5183**

If you do not get confirmation of receipt,  
send **SECURE** email to  
[PHNOlderAdult@acgov.org](mailto:PHNOlderAdult@acgov.org)  
For questions, please call **510-577-7037**

Older Adults, Healthy Results is a home-visiting, public health nurse case management program that works with clients who are having trouble managing complex health conditions due to psychosocial challenges.

**Eligibility criteria:**

- 60 years of age or older
- Eligible for full scope Medi-Cal
- Medically complex (2+ medical conditions)
- At least one functional impairment
- Have decision-making capacity (or surrogate)
- Agree to accept case management services

**We do NOT accept the following referrals:**

- Primarily psychiatric or substance abuse needs
- Have a need for urgent or daily intervention
- In need of placement to a higher level of care
- End-stage of disease and need palliative care
- Already receiving comprehensive case management
- Berkeley residents (Refer to City of Berkeley Aging Services)

**\*\*Note: There may be a delay between referral and intake. Older Adults, Healthy Results maintains a waitlist. Referred clients will be contacted when space is available\*\***

<b>Client name:</b>		Phone:	
		DOB:	
<b>Contact person:</b>		SSN:	
Phone:		Preferred language:	
Address: _____			
	Street	City	State      Zip

<b>Problems to be addressed:</b>
<b>Desired goals for RN case management:</b>
<b>Other referrals made/services currently received:</b>
<input type="checkbox"/> VA <input type="checkbox"/> IHSS <input type="checkbox"/> Regional Center <input type="checkbox"/> Non-nurse case management <input type="checkbox"/> Other: _____ <input type="checkbox"/> APS <input type="checkbox"/> MSSP <input type="checkbox"/> Home health <input type="checkbox"/> Specialty mental health

<b>MEDICAL CONDITIONS:</b>	<b>Medical provider:</b>	<b>Phone:</b>
		<b>Fax:</b>
	<b>Insurance:</b>	<b>MediCal managed care plan:</b>
	<input type="checkbox"/> Medi-Cal - SOC: \$_____	<input type="checkbox"/> Alameda Alliance for Health
<b>BEHAVIORAL HEALTH:</b>	<input type="checkbox"/> Medi-Cal/Medicare	<input type="checkbox"/> Kaiser
	<input type="checkbox"/> Other: _____	

<b>Referrer Name:</b>	<b>Phone:</b>
<b>Affiliation/agency:</b>	<b>Fax:</b>

**\*\*PREFERRED: PLEASE INCLUDE A PROBLEM LIST, RECENT CLINIC NOTE OR DISCHARGE SUMMARY, AND MEDICATION LIST\*\***