Transgender Health Services
Surgery Aftercare Referrals

☐ IHSS (DAAS)

Service Summary
- Patient Eligible for 8 Hours Per Week (2 hours per day)
- Patients with HSF can receive 2 weeks of service
- Patients with Medi-Cal and Medicare can receive >2 weeks of care if needed
- Case worker assigned to patient will evaluate patient needs after discharge and
determine length of coverage.

Referral Process
- Requires that patient complete Form 3012 submit to DAAS Intake
  o Form can be submitted 2 weeks before expected discharge date
  o Expedited service requires selecting “Emergency On Call Requested” on Form
    3012. Reason for emergency need could include, “patient lives alone” or
    “patient without support person.”
  o Patient will be assigned a case manager who will
- Between admission and discharge, a licensed medical provider will need to complete
  and submit a health certificate called Form 873. Form also requires patient’s signature.

☐ Transportation (Paratransit)

Service Summary
- Patients need to reserve a ride at least the day before a ride is needed and up to seven
days in advance.
- Patients may be dropped off 60 min before scheduled appointment and may need to
  wait 30-60 minutes after appointment for pick up.
- For patient needing rides within San Francisco:
  o Scheduling line open 7am-6pm: 415-285-6945
  o Cost $2.25
- For patients needing rides to Dr. Crane’s Office in Greenbrae:
  o Address is: 575 Sir Francis Drake Road
  o Marin Paratransit will transport people from SF to Marin and back. Depending
    on a patient’s address, patient may have to wait at a bus stop.
  o Marin Paratransit Scheduling Line open 8am-5pm: 415-454-0964
- For patients needing rides to Dr. Bowers in Burlingame:
  o Address is: 345 Lorton Ave, Ste 101
  o Patients will need to take two forms of paratransit
    ▪ SF Paratransit to Stonestown scheduling line 7am - 6pm: 415-285-6945
    ▪ San Mateo Redi-Wheels to Burlingame scheduling line 830am-5pm:
      650-366-4856
  o Total cost: $2.25 to SF Paratranist to Stonestown
    + $3.75 to San Mateo Redi-Wheels Stonestown to San Mateo

Referral Process
- Fill out application at least 21 days in advance
Transgender Health Services
Surgery Aftercare Referrals

☐ Health at Home

Service Summary
- Skilled nursing provided in patient’s residence. Visit frequency depends on assigned nurse’s assessment of patient need. Typical frequency is x2 per week.
- Wound care, medical supplies, physical needs assessment, medical advice
- Encourage patients to ask for additional supplies from assigned nursing staff, if needed.

Referral Process
- Referral initiated through LCR e-Referral under “Other Programs”
- Referrals can be initiated 2 weeks in advance of anticipated discharge date

☐ Food Delivery (Open Hand)

Service Summary
- One hot meal delivered 1 x day, 7 meals per week, duration of 6 weeks post surgery
- Patients can opt for bland, vegetarian, diabetic, and regular meals

Referral Process
- Requires Completion of Open Hand Application
- Form can be completed by medical social worker, doctor, nurse practitioner
- Form can be submitted 2 weeks before meals will be needed

☐ Post-Surgical Supplies

Vendor Summary
- Sincere Care
  Supplies Available
  - Incontinence supply request form contains supplies for vaginoplasty including: pads, diapers, and chux. Maximum monthly allowance, can be re-ordered each month
  - Lube available for dilation
    - Product Name: “Reliagel”
    - Product Code: A4332
    - Requires letter of request describing medical necessity of product and signature

Eligibility
- Medi-Cal (SFHP) and Medicare
- HSF only when patients are getting care at SFGH

Ordering Process
- Complete and fax in request form or physician letter to vendor
- Vendor delivers supplies directly to patient’s residence

Version date 9/30/2014
In-Home Supportive Services Referral Form

Date Sent: [Date]

Fax to SF HSA Department of Aging and Adult Services Program: (415) 557-5271
Questions? Call: (415) 355-6700 or email us at: ihss@ci.sf.ca.us

IHSS Applicant

Spouse (If in the home)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Sex (M/F)</th>
<th>Transgender (Y/N)</th>
<th>Sexual Orientation</th>
<th>Soc. Sec. Number</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Sex (M/F)</th>
<th>Transgender (Y/N)</th>
<th>Sexual Orientation</th>
<th>Soc. Sec. Number</th>
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</tbody>
</table>

Street Address Apt# Zip Phone

Is Spouse an IHSS Recipient? [Y] [N]

Ethnicity: Languages:

Is Spouse able to do housework? [Y] [N]

If no, why not?

Does applicant receive Supplemental Security Income (SSI)? [Y] [N]

Spouse’s MD Information:

Name:
Address:
City:
CA Zip:
Phone: ( ) Fax: ( )

Emergency Contact Name:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation</th>
<th>Phone: ( )</th>
<th>Please circle one: CELL-HOME-WORK</th>
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<tbody>
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<td></td>
<td>CELL-HOME-WORK</td>
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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation</th>
<th>Phone: ( )</th>
<th>Please circle one: CELL-HOME-WORK</th>
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<td></td>
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<td></td>
<td>CELL-HOME-WORK</td>
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</tbody>
</table>

Others in Household: Lives Alone [ ] Number of Household Members: ( )

Other IHSS Recipients in household? [Y] [N]

If yes, Soc. Sec. Number: -

Name of IHSS Recipient:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Relation</th>
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</table>

Medical Information

Diagnosis / Medical Condition:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MD Name:</th>
</tr>
</thead>
<tbody>
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</table>

Address:
City: CA Zip:
Phone: ( ) Ext: 
Fax: ( ) Ext:

Comments:

Referent Name: For non self-referrals, please attach applicant’s signature of Authorization for Release of Information:

Phone: ( ) ext.

Agency: Relation:

If hospitalized, Hospital: Campus/Site: Room: Bed: Floor:

Most Recent or Anticipated discharge date / /

Emergency On-Call Home Care

Is emergency on-call home care requested? [Y] [N] ***We are UNABLE TO AUTHORIZE “ER” services without the health care certification form SOC 873***

*If yes, why are emergency services needed?
The information on this page will help us assess your needs and respond to your request for services. If the form is not completed in full, your application will not be accepted.

*We are unable to authorize emergency on-call home care services without the provision of this information*

### Functional Ability

<table>
<thead>
<tr>
<th></th>
<th>Unknown</th>
<th>Independent</th>
<th>Verbal Assist</th>
<th>Some human help</th>
<th>Lots of human help</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
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<tr>
<td>Dressing</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Transfer mobility</td>
<td></td>
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<tr>
<td>Grooming</td>
<td></td>
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<tr>
<td>Ambulating (walking)</td>
<td></td>
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<tr>
<td>Telephone</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Mobility indoors</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Managing money</td>
<td></td>
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<tr>
<td>Mobility Outdoors</td>
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<td></td>
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<tr>
<td>Light housework</td>
<td></td>
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<tr>
<td>Stair climbing</td>
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<tr>
<td>Heavy housework</td>
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<tr>
<td>Managing medicines</td>
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<tr>
<td>Laundry</td>
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<tr>
<td>Shopping</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Meal prep &amp; clean up</td>
<td></td>
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</tbody>
</table>

### Risks

<table>
<thead>
<tr>
<th>Does the client currently exhibit or have history of...</th>
<th>Active</th>
<th>Past History</th>
<th>Unknown</th>
<th>Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Financial management/Eviction</td>
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</tr>
</tbody>
</table>

### Support System

How are your service needs currently being met? Please be as specific as possible and include information about current caregiver(s) and areas of need.

How will you be able to meet your service needs until IHSS eligibility and services are established?

### Services

Please list any services you currently receive:

- [ ] On Lok Lifeways/PACE program (a comprehensive Medi-Cal program that offers services including adult day health care, in-home care, and medical services for seniors 55+, with stable housing & NF/ICF/SNF eligible)
- [ ] Adult Day Health Care through Community-Based Adult Services (CBAS)
- [ ] Other services:

***Please note that in order to receive IHSS you must be on full-scope Medi-Cal and may still have a share of cost (based on your income). Our staff can assist you in applying for Medi-Cal coverage.***
IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM
HEALTH CARE CERTIFICATION FORM

A. APPLICANT/RECIPIENT INFORMATION (To be completed by the county)

Applicant/Recipient Name: ____________________________ Date of Birth: ____________

Address: ____________________________________________

County of Residence: ________________________________ IHSS Case #: __________________

IHSS Worker Name: ________________________________

IHSS Worker Phone #: ________________________________ IHSS Worker Fax #: ____________

B. AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
(To be completed by the applicant/recipient)

I, ____________________________________________, authorize the release of health care information related to my physical and/or mental condition to the In-Home Supportive Services program as it pertains to my need for domestic/related and personal care services.

Signature: ____________________________ Date: ____________

(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Witness (if the individual signs with an "X"): ____________________________ Date: ____________

TO: LICENSED HEALTH CARE PROFESSIONAL* –

The above-named individual has applied for or is currently receiving services from the In-Home Supportive Services (IHSS) program. State law requires that in order for IHSS services to be authorized or continued a licensed health care professional must provide a health care certification declaring the individual above is unable to perform some activity of daily living independently and without IHSS the individual would be at risk of placement in out-of-home care. This health care certification form must be completed and returned to the IHSS worker listed above. The IHSS worker will use the information provided to evaluate the individual’s present condition and his/her need for out-of-home care if IHSS services were not provided. The IHSS worker has the responsibility for authorizing services and service hours. The information provided in this form will be considered as one factor of the need for services, and all relevant documentation will be considered in making the IHSS determination.

IHSS is a program intended to enable aged, blind, and disabled individuals who are most at risk of being placed in out-of-home care to remain safely in their own home by providing domestic/related and personal care services. IHSS services include: housekeeping, meal preparation, meal clean-up, routine laundry, shopping for food or other necessities, assistance with respiration, bowel and bladder care, feeding, bed baths, dressing, menstrual care, assistance with ambulation, transfers, bathing and grooming, rubbing skin and repositioning, care/assistance with prosthesis, accompaniment to medical appointments/alternative resources, yard hazard abatement, heavy cleaning, protective supervision (observing the behavior of a non-self-directing, confused, mentally impaired or mentally ill individual and intervening as appropriate to safeguard recipient against injury, hazard or accident), and paramedical services (activities requiring a judgment based on training given by a licensed health care professional, such as administering medication, puncturing the skin, etc., which an individual would normally perform for him/herself if he/she did not have functional limitations, and which, due to his/her physical or mental condition, are necessary to maintain his/her health). The IHSS program provides hands-on and/or verbal assistance (reminding or prompting) for the services listed above.

*Licensed Health Care Professional means an individual licensed in California by the appropriate California regulatory agency, acting within the scope of his or her license or certificate as defined in the Business and Professions Code. These include, but are not limited to: physicians, physician assistants, regional center clinicians or clinician supervisors, occupational therapists, physical therapists, psychiatrists, psychologists, optometrists, ophthalmologists and public health nurses.
C. HEALTH CARE INFORMATION (To be completed by a Licensed Health Care Professional Only)

NOTE: ITEMS #1 & 2 (AND 3 & 4, IF APPLICABLE) MUST BE COMPLETED AS A CONDITION OF IHSS ELIGIBILITY.

1. Is this individual unable to independently perform one or more activities of daily living (e.g., eating, bathing, dressing, using the toilet, walking, etc.) or instrumental activities of daily living (e.g., housekeeping, preparing meals, shopping for food, etc.)? [ ] YES [ ] NO

2. In your opinion, is one or more IHSS service recommended in order to prevent the need for out-of-home care (See description of IHSS services on Page 1)? [ ] YES [ ] NO

   If you answered “NO” to either Question #1 OR #2, skip Questions #3 and #4 below, and complete the rest of the form including the certification in PART D at the bottom of the form.

   If you answered “YES” to both Question #1 AND #2, respond to Questions #3 and #4 below, and complete the certification in PART D at the bottom of the form.

3. Provide a description of any physical and/or mental condition or functional limitation that has resulted in or contributed to this individual’s need for assistance from the IHSS program:

4. Is the individual’s condition(s) or functional limitation(s) expected to last at least 12 consecutive months? [ ] YES [ ] NO

Please complete Items # 5 - 8, to the extent you are able, to further assist the IHSS worker in determining this individual’s eligibility.

5. Describe the nature of the services you provide to this individual (e.g., medical treatment, nursing care, discharge planning, etc.):

6. How long have you provided service(s) to this individual?

7. Describe the frequency of contact with this individual (e.g., monthly, yearly, etc.):

8. Indicate the date you last provided services to this individual: _____ / _____ / _____

NOTE: THE IHSS WORKER MAY CONTACT YOU FOR ADDITIONAL INFORMATION OR TO CLARIFY THE RESPONSES YOU PROVIDED ABOVE.

D. LICENSED HEALTH CARE PROFESSIONAL CERTIFICATION

By signing this form, I certify that I am licensed in the State of California and/or certified as a Medi-Cal provider, and all information provided above is correct.

Name: ____________________________________________________________________________

Title: ____________________________________________________________________________

Address: ____________________________________________________________________________

Phone #: ____________________________________________________________________________ Fax #: ____________________________________________________________________________

Signature: ____________________________________________________________________________ Date: ____________________________________________________________________________

Professional License Number: ____________________________________________________________________________

Licensing Authority: ____________________________________________________________________________

PLEASE RETURN THIS FORM TO THE IHSS WORKER LISTED ON PAGE 1.
Application for ADA Paratransit Service

IMPORTANT INFORMATION FOR APPLICANTS

This packet includes information and forms you need to apply for paratransit eligibility in the San Francisco Bay Area. As part of the requirements of the Americans with Disabilities Act (ADA), paratransit service is provided by all public transportation systems. This special type of public transportation service is limited to persons who are unable to independently use regular public transit, some or all of the time, due to a disability or health related condition.

In order to use ADA paratransit service, you must be certified as eligible. Eligibility is determined on a case-by-case basis. According to ADA regulations, eligibility is strictly limited to those who have specific limitations that prevent them from using accessible public transportation.

Your application may be approved for full eligibility (unconditional) or on a limited basis for some trips only (conditional eligibility). If you are found to be capable of using regular bus and rail transit for all trips, without the help of another person, you will not be eligible for paratransit.

To apply for eligibility you must fully complete the attached application form. We will review your ability to use accessible public transportation. After studying your application, we may need more information. We may need to:

- Contact you by phone
- Schedule a personal interview or a functional evaluation, or
- Consult with your doctor, health professional, or other specialist about your condition and abilities

For:
- Braille,
- Large Print,
- Audio Tape
  Or
- Computer Diskette/ CDR

Call (415) 351-7000

Applicants and persons assisting them are encouraged to read the brochure called “Accessible Transportation in the San Francisco Bay Area” before completing the attached form. If you need a brochure call your transit agency. It provides more details about ADA paratransit and the criteria for eligibility.
Your application will be processed within 21 days after it has been received. The application must be properly completed and you must make yourself available for a second level assessment if requested. A second level assessment could include a telephone interview with you, medical verification, or an in-person interview. The in-person interview may include a functional test to determine your ability to take a public transit trip, such as being capable of walking to a bus stop, reading signs etc.

You will receive notice of your eligibility determination by mail. If you are certified as eligible, you will be eligible to travel throughout the nine-county Bay Area. If you do not agree with the eligibility determination, you have the right to appeal. Information on how to file an appeal will be included with your eligibility notice. If an eligibility determination takes longer than 21 days, you may be given eligibility that allows you to use the paratransit system until a final decision about your eligibility is made. This does not apply if, through inactions on your part, we are unable to complete the processing of your application.

INSTRUCTIONS FOR APPLICANTS

1. Please PRINT OR TYPE full responses to all of the questions on the application form. Your detailed responses and explanations will help us make an appropriate determination. Be sure to respond to ALL questions or your application will be considered incomplete. Incomplete applications will be returned.

2. You are not required to attach additional pages or information. However, you may want to send other documents that you think will help us understand your limitations. All information that you supply will be kept strictly confidential.

3. You must provide SIGNATURES in two places to complete the application:
   - Applicant Certification (Page 8)
   - Authorization to Release Information for an appropriate medical or rehabilitation professional (Page 9)

4. Return the completed application to: SF Paratransit
   68 12th Street, 1st Floor, San Francisco, CA 94103.

   For help with the application process or to check on the status of your application call (415)351-7050.

Thank you
Please Print

Personal/Contact Information

Name (first, middle, last):

________________________________________

Home Address: ___________________________ Apt. #: __________

City: ___________________________ Zip: ______

Mailing Address (if different from home):

________________________________________ Apt. #: __________

City: ___________________________ Zip: ______

Daytime Phone: (____) ___________ TDD/TTY: (____) ________

Evening Phone: (____) ___________ Cell Phone: (____) ________

Birth Date: ___/___/____  □ Female  □ Male

Primary Language (please check):  □ English  □ Other (specify) __________

If you need any future written information provided to you in an accessible format, please check which format you prefer:

□ Diskette/CDR  □ Audio tape  □ Braille  □ Large Print

□ Other ______________________________________________________________________

In case of emergency, whom should we contact?

Name: ___________________________________________

Relationship: _________________________________

Day Phone: (____) ___________  Eve. Phone: (____) ________
Tell Us About Your Disability / Health Related Condition

Please answer the following questions in detail – your specific answers to the questions will help us in determining your eligibility.

1. Which disability or health related conditions **PREVENT** you from using regular public transit without the help of another person (i.e. BART, bus, streetcar)?

2. Briefly explain **HOW** your condition prevents you from using regular public transit without the help of another person.

3. When did you first experience the conditions you described above?
   - [ ] 0-1 year ago
   - [ ] 1 – 5 years ago
   - [ ] Longer than 5 years

4. Do the conditions you described change from day to day in a way that affects your ability to use public transit?
   - [ ] Yes, good on some days, bad on others.
   - [ ] No, doesn’t change.
   - [ ] Don’t know.

5. Are the conditions you described:
   - [ ] Permanent
   - [ ] Temporary
   - [ ] Don’t Know
   *If temporary, how long do you expect this to continue?*
Tell Us About Your Capabilities and Usual Activities

6. Do you use any of the following mobility aids or specialized equipment? *(Check all that apply):*
- [ ] Cane
- [ ] Power Wheelchair
- [ ] Communication Devices
- [ ] White Cane
- [ ] Service Animal
- [ ] Walker
- [ ] Power Scooter
- [ ] Crutches
- [ ] Manual Wheelchair
- [ ] Leg Braces
- [ ] Portable Oxygen Tank
- [ ] Other Aid

7. Please check the box that best describes your current living situation:
- [ ] 24 hour care or Skilled Nursing Facility
- [ ] Assisted Living Facility
- [ ] I receive assistance from someone that comes to my home to help with daily living activities
- [ ] I live with family members who help me
- [ ] I live independently (without the assistance of another person)

8. How many city blocks can you travel with your usual mobility aid and without the help of another person?

9. Which of the following statements best describes you if you had to wait outside for a ride? *(Check only one response):*
- [ ] I could wait by myself for ten to fifteen minutes
- [ ] I could wait by myself for ten to fifteen minutes only if I had a seat and shelter
- [ ] I would need someone to wait with me because

10. Which of the following statements best describes you? *(Check only one response):*
- [ ] I have never used regular public transit
- [ ] I have used regular public transit but not since the onset of my disability
- [ ] I have used regular public transit within the last six months
11. How do you currently travel to your frequent destinations? (Check all that apply):
   □ Buses    □ Paratransit    □ Drive myself    □ BART
   □ Taxi      □ Ferry         □ Streetcar    □ Someone drives me
   □ Other

12. Do you travel with the help of another person?
   □ Always    □ Sometimes    □ Never

   12a. If “always” or “sometimes”, what type of help do they provide?


13. Would you be able to get to and from the public transit stop nearest your home?
   □ Yes       □ No          □ Sometimes
   If no or sometimes, explain why:


14. Would you be able to grasp handles or railings, coins or tickets while boarding or exiting a transit vehicle?
   □ Yes       □ No          □ Sometimes    □ Don’t know, never tried it
   If no or sometimes, explain why:


15. Would you be able to maintain balance and tolerate movement of a public transit vehicle when seated?
   □ Yes       □ No          □ Sometimes    □ Don’t know, never tried it
   If no or sometimes, explain why:
16. Would you be able to get on or off a public transit bus if it has either a lift, a ramp, or a kneeler that lowers the front of the bus?
   □ Yes   □ No   □ Sometimes   □ Don't know, never tried it

   If no or sometimes, explain why:

   ________________________________________________________________

   ________________________________________________________________

17. Please add any other information that you would like us to know about your abilities.

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________

   ________________________________________________________________

Have you answered all the questions and provided explanations where required?

INCOMPLETE APPLICATIONS WILL BE RETURNED.
**Applicant Certification**

I **certify** that the information in this application is **true** and **correct**. I understand that knowingly falsifying the information will result in denial of service. I understand all information will be kept confidential, and only the information required to provide the services I request will be disclosed to those who perform the services.

I understand that it may be necessary to contact a professional familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

**Sign here:**

Applicant's signature ___________________________ Date ______

**Did someone help you in filling out this form?**  □ Yes  □ No

If yes, Name: ___________________________ Phone: (____) ____________

Relationship: ___________________________

Please Note: It is your responsibility to notify us if your disability improves enough to change your eligibility status. If your condition improves after you have been determined eligible or we discover you submitted false information, your eligibility could be suspended or you may be asked to re-apply.
Authorization to Release Medical Information

(to be completed by applicant)

I hereby authorize the following licensed professional (doctor, therapist, social worker, etc.) who can verify my disability or health related condition, to release this information to my local public transit agency. This information will be used only to verify my eligibility for paratransit services. I understand that I have the right to receive a copy of this authorization, and that I may revoke it at any time.

Name of Professional who may release my medical information:

Address:

Medical Record or ID #, if known:

Telephone

Fax

Sign here:

Applicant’s signature ____________________________ Date ________
AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

To: ________________________________ (Insert name of Physician or Provider)

I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") to ATC Paratransit for purposes of determining my eligibility to receive transportation services.

Patient’s Name: ____________________________ Today’s Date ____________________________

Please send requested information to:

San Francisco Paratransit, 68 12th Street, San Francisco, CA 94103

Specific description of Protected Health Information to be used or disclosed:

Our applicant’s, your patient’s documented disability(ies) and how it(they) affect his/her ability to independently use Muni or BART’s otherwise accessible buses/trains.

Event after which this Authorization expires:

Professional verification of specific information being requested (see above) which allows us to make an ADA Paratransit eligibility determination.

I understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization and that the released Protected Health Information may no longer be protected by federal privacy regulations. I also understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on any actions you took before you received the revocation of this Authorization.

_________________________________________ ________________
Signature of individual or individual’s representative Date

(Form MUST be completed before signing)

If applicable, printed name of individual’s representative: __________________________________________

Relationship to the individual: __________________________________________

_________________________________________ ________________
Witness Date

(This form is available in accessible formats and/or alternative languages upon request.)
# Project Open Hand Application for Services (subject to eligibility)

## 1. Client Consent to Release Information:

I authorize my medical provider to release information about my medical condition to Project Open Hand for purposes of verifying my eligibility.

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Date of birth:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Signature:</td>
<td>Date:</td>
<td>County:</td>
</tr>
</tbody>
</table>

**Healthcare Provider only Below this Line:**

## 2. SERVICE DURATION:

- 3 months
- 6 months

## 3. PRIMARY DIAGNOSIS: Required for any services. Check all that apply.

- NO PRIMARY DIAGNOSIS
- HIV+/AIDS *(Please provide client labs in Section 9)*
- Cancer, active diagnosis
  - Specify type and stage
  - Chemotherapy and/or radiation therapy and/or Hormone therapy w/debilitating side effects *(circle all that apply)*
- End stage renal disease (ESRD)
  - Dialysis type and frequency
- Diabetes *(Please provide client labs in Section 9):*
  - Type 1 or 2 *(circle one)*
- End stage Liver Disease (ESLD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Hepatitis C
- Multiple Sclerosis
- Serious Neurologic Condition/Stroke/Parkinson’s
- Autoimmune disease *(e.g. Lupus)*
- ALS *(Lou Gehrig’s disease)*

- Trauma/Major Surgery *(within 30 days)* **Type**

**Note:** *(6 WEEKS SERVICE ONLY)*

## 4. SYMPTOMS: Check any exhibited in the past 30 days.

- NO SYMPTOMS
- Chronic *(>30 days, circle those that apply)*, intractable diarrhea, nausea, or vomiting that inhibits normal daily function
- Unintentional weight loss of more than 5% of baseline body weight in 1 month *(Or 10% in 6 months)*
- Uncontrolled Diabetes
- Inability to gain weight if underweight *(provide parameters)*
- Oral conditions preventing adequate nutritional intake
- Peripheral neuropathy, significantly limited standing and/or ambulation
- An opportunistic infection inhibiting ability to prepare and/or access meals *(describe):*

**Start Date:**

**Anticipated Duration:**

- Cognitive deficit inhibiting ability to prepare and/or access meals. Describe:
- Hospice or palliative care.
- Severe shortness of breath at rest.
- Muscle weakness in one or more of the following: hands, arms, legs or the muscles of speech, swallowing or breathing.
- Severe swelling in ankle or feet limiting standing and/or ambulation.
- Twitching *(fasciculation)* and cramping of muscles.
- Anemia
- Mild Wasting
- Severe pain
- Hypertension
- Spasticity
- Severe Fatigue
- Mild Diarrhea
- Hyperlipidemia
- Lymphedema
- Ataxia
- Slow-healing sores

**Signature of Provider**

**Printed Name of Provider**

**Office Stamp**

**Address, Phone and Fax**

**Date**
Application For Services (subject to eligibility)

Client Name: ________________________________

6. OTHER FACTORS: (Any exhibited in the past 30 days that may impact client’s ability to access services.)

☐ Mental Illness (DSMIV diagnosis: ____________________________)
☐ Substance Use (please describe: ____________________________)
☐ Developmental disability

7. Delivery Services: (Available for client’s with restricted mobility.)

☐ CLIENT IS ABLE TO PICK UP MEALS or CLIENT HAS SUPPORT PERSON TO PICK UP MEALS
☐ Client in need of delivery for ___ months due to: (Maximum 6 mo.; check all that apply)

☐ Bed Bound.
☐ Unlikely able to stand for more than 15 minutes at a time.
☐ Unlikely able to walk more than 50 feet at a time.
☐ Unlikely able to carry a weight of more than 15 lbs.
☐ Likely to need physical or other assistance in leaving home.
☐ Requires 24hrs/day oxygen to treat lung or heart disease.
☐ Requires someone to help client prepare/cook food. (If checked, circle one)
☐ Leaving home may create safety risk or hardship.

8. Physical DATA: (Must be included to determine eligibility)

Height: ___ ft. ___ in.
Current Weight: _________ lbs.
Usual body weight: _________ lbs.
Weight loss □ gain □ of _________ lbs. over _________ months.

9. Clinical DATA: (Must be included to determine eligibility)

Please indicate if DATA is unavailable by writing in N/A

Blood Pressure: __________/__________ Date: __________
CD4 cell count: _________ (HIV) Date: __________
HIV Viral Load: _________ (HIV) Date: __________
HbA1c _________ (Diabetes) Date: __________
Total Cholesterol: _________ Date: __________
HDL/LDL: _________/_______ Date: __________
Triglycerides _________ Date: __________

Signature of Provider

Printed Name of Provider

Office Stamp

Address, Phone and Fax

Date
Incontinence Supplies Prescription Form (Medi-Cal)

Patient Last, First Name: ___________________________ Date of Birth: ___________________________
Contact Number: ___________________________ Alternative Contact Number: ___________________________

DIAGNOSIS
1. Patient is incontinent of: ( ) Bowel ( ) Bladder ( ) Both

2. Medical condition/diagnosis causing Bowel or Bladder incontinence:

3. Type of urinary incontinence: ( ) Overflow ( ) Stress ( ) Urge ( ) Functional ( ) Mixed

4. Type of Bowel incontinence: ( ) Nervous System Pathology ( ) Functional (for example, Chronic Constipation)

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<th>PRODUCT CODE</th>
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<th>MONTHLY USAGE</th>
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Prescription valid for 12 months

Prescribing Physician’s Verification (Physician Use Only)
I have reviewed my patient’s medical records and the items requested above. I verify that I have physically examined the patient within the last 12 months and have established that this patient has a chronic pathologic condition which is causally related to his/her incontinence and that other treatment options are not appropriate to decrease or eliminate incontinence. I have prescribed the items described above which I have determined to be medically necessary for this patient. I will maintain a copy of this prescription in the recipient’s medical record to meet Medi-Cal documentation requirements.

Physician’s Name and Address (Please print or type):

Physician’s Signature: ___________________________ Date: ___________________________
Physician’s Name (Print): ___________________________ NPI #: ___________________________
Address: ________________________________________
Physician’s Telephone #: ___________________________ Fax #: ___________________________

Revised on 11/17/2009
[DATE]

To Whom It May Concern,

Patient [NAME], DOB [XX/XX/XX], Insurance Plan [NAME], Insurance ID Number: [XXXXXXXXXXX] is s/p for vaginoplasty and requires water-based lubrication to facilitate ongoing 3x daily post-surgical dilation.

This is a request for ReliaMed Lubricating Jelly, Product Code: A4332, in the amount of 10 tubes (4oz each).

Physician’s Signature:

Physician’s Name:
Certificate Number:
Address:
Telephone:
Fax: