

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
 - Form can be submitted **2 weeks** before expected discharge date
 - 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."
 - 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:
 - Scheduling line open 7am-6pm: **415-285-6945**
 - Cost \$2.25
- For patients needing rides to Dr. Crane's Office in Greenbrae:
 - Address is: 575 Sir Francis Drake Road
 - 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.
 - Marin Paratransit Scheduling Line open 8am-5pm: **415-454-0964**
- For patients needing rides to Dr. Bowers in Burlingame:
 - Address is: 345 Lorton Ave, Ste 101
 - 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**
 - Total cost: \$2.25 to SF Paratransit 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



In-Home Supportive Services Referral Form

Date Sent:

Please answer all questions and print clearly

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)

Last Name			First Name			MI		
/ /			Sex (M/F) ___/Transgender (Y/N) ___			- -		
Birth date			Sexual Orientation			Soc. Sec. Number		
Street Address			Apt#			Zip		
Ethnicity:			Languages:			Phone () -		
Does applicant receive Supplemental Security Income (SSI)? Y <input type="checkbox"/> N <input type="checkbox"/>			Is Spouse an IHSS Recipient? Y <input type="checkbox"/> N <input type="checkbox"/>			Is Spouse able to do housework? Y <input type="checkbox"/> N <input type="checkbox"/>		
Is the applicant enrolled in Medi-Cal? Y <input type="checkbox"/> N <input type="checkbox"/>			If no, why not?			Spouse's MD Information:		
						Name:		
						Address:		
						City:		
						CA Zip:		
						Phone: () - Fax: () -		

Emergency Contact Name:

Last name		First name		Relation:		Phone: () -	
						Please circle one: CELL-HOME-WORK	
Last name		First name		Relation:		Phone: () -	
						Please circle one: CELL-HOME-WORK	
Others in Household:		Lives Alone <input type="checkbox"/>		Number of Household Members: ()			
Other IHSS Recipients in household? Y <input type="checkbox"/> N <input type="checkbox"/>		If yes, Soc. Sec. Number: - -					
Name of IHSS Recipient:		Last name		First name		Relation:	

Medical Information

Diagnosis/ Medical Condition:		MD Name:	
		Last Name	
		First Name	
		Address:	
		City:	
		CA Zip:	
		Phone: () - Ext:	
		Fax: () - Ext:	

Comments:

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

Last name		First name		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 <input type="checkbox"/> N <input type="checkbox"/>		***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

	Unknown	Independent	Verbal Assist	Some human help	Lots of human help	Dependent
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulating (walking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stair climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal prep & clean up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risks

Does the client currently exhibit or have history of...	Active	Past History	Unknown	Explain
Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financial management/Eviction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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:

Are you interested in learning more about the following services?

☐ 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
(PRINT NAME)
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.*

IN-HOME SUPPORTIVE SERVICES (IHSS) PROGRAM HEALTH CARE CERTIFICATION FORM

Applicant/Recipient Name:

IHSS Case #:

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):
- | | | |
|--|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Communication Devices |
| <input type="checkbox"/> White Cane | <input type="checkbox"/> Service Animal | <input type="checkbox"/> Walker |
| <input type="checkbox"/> Power Scooter | <input type="checkbox"/> Crutches | <input type="checkbox"/> Manual Wheelchair |
| <input type="checkbox"/> Leg Braces | <input type="checkbox"/> Portable Oxygen Tank | |
| <input type="checkbox"/> 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

Tell Us About Your Travel Needs

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.)

REFERRED BY: _____ PHONE _____ FAX _____

PROJECT OPEN HAND

730 Polk Street, San Francisco, CA 94109 415/447-2326 Fax: 415/447-2492
1921 San Pablo Avenue, Oakland, CA 94612 510/622-0221 Fax: 510/452-1061

Application For Services (subject to eligibility)



Project Open Hand
meals with love

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.

Client Name: _____

Date of birth: _____

Phone: _____

Client Signature: _____

Date: _____

County: _____

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 _____

Date _____ (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

v080114

REFERRED BY: _____ PHONE _____ FAX _____

PROJECT OPEN HAND

730 Polk Street, San Francisco, CA 94109 415/447-2326 Fax: 415/447-2492
1921 San Pablo Avenue, Oakland, CA 94612 510/622-0221 Fax: 510/452-1061

Application For Services (subject to eligibility)



Project Open Hand
meals with love

Client Name: _____

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

- ☐ Mental Illness (DSMV 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: _____

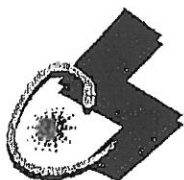
Signature of Provider

Printed Name of Provider

Office Stamp
v080114

Address, Phone and Fax

Date


健誠 醫療器材
Sincere Care Medical Supply

2272 Palou Ave, San Francisco, CA 94124 ♦ Tel: (415) 752-3288 ♦ Fax: (415) 759-8900

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)

Order	PRODUCT TYPE	PRODUCT SIZE	PRODUCT CODE	DAILY USAGE	MONTHLY USAGE	TOTAL UNITS PER YEAR
	Disposable Brief	SM	T4521	7	192	2304
		MD	T4522	7	192	2304
		LG	T4523	5	144	1728
		XL	T4524	6	180	2160
	Disposable Underpad		T4541	4	120	1440
	Liner / Belted Undergarment		T4535	6	180	2160
	Protective Underwear	SM	T4525	4	110	1320
		MD	T4526	4	120	1440
		LG	T4527	4	108	1296
		XL	T4528	4	120	1440
	Reusable Underwear		T4536		2	24
	Waterproof Sheeting		T4537		1/6 MOS	2

 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 #: _____

[DATE]

To Whom It May Concern,

Patient [NAME], DOB [XX/XX/XX], Insurance Plan [NAME], Insurance ID Number: [XXXXXXXXXXXX] is s/p for vagionplasty 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: