SAN FRANCISCO HEALTH PLAN
Here for you

Community-Based Adult Services (CBAS) Referral Form

Please complete this form and fax it to the Institute on Aging: (415) 750-5338

MEMBER INFORMATION

Date:	Date of Birth (DOB):
Last Name, First Name:	
CIN/Medi-Cal#:	SFHP ID#:

Primary Language: ☐ English ☐ Cantonese ☐ Mandarin ☐ Russian ☐ Spanish ☐ Other (Write in):

Interpreter Needed? ☐ YES ☐ NO

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other:

Member Address: City: State: Zip:

Phone:

REQUESTING CBAS PROVIDER / AGENCY INFORMATION

Referral Source:

Relationship to Member:

First Choice:

Second Choice:

Third Choice:

*Choose from **A - J** for your first, second, and third choice of the Adult Day Health Centers below:*

A. No Preference
B. Bayview Hunters Point Adult Day Health Care Center
C. Circle of Friends Adult Day Health Care
D. Golden State Adult Day Halth Care
E. L'Chaim Adult Day HealthCenter
F. Self-Help for the Elderly Adult Day Services
G. SteppingStone Golden Gate Day Health
H. SteppingStone Mabini Day Health
I. SteppingStone Mission Creek Day Health
J. SteppingStone Presentation Day Health

Contact Person:

Phone: Fax:

Address: City: State: Zip:

CBAS REFERRAL INITIATION

Referral Date:

☐ Check this box if you would like to initiate a CBAS referral to determine CBAS eligibility.

- Is this an urgent request? ☐ YES ☐ NO
- If yes, why:

Reason for Referral:

☐ Medical care and medication compliance oversight
☐ Injury and fall prevention/safety support
☐ Psychological support services
☐ Special health services (rehabilitation, nutrition, and personal care)
☐ Respite
☐ Other

See reverse

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CEDT ASSESSOR DISPOSITION	
Date of Initail Assessment:	
☐ Approved as Requested	
☐ Denied–Justification/Notes:	
☐ Case Closed–Justifiaction/Notes:	
By (CEDT Assessor):	Date: