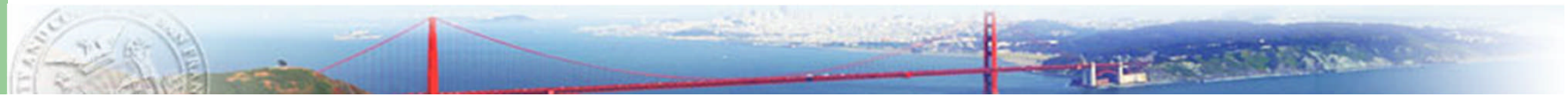
Department of Aging & Adult Services

Navigating Integrated Intake

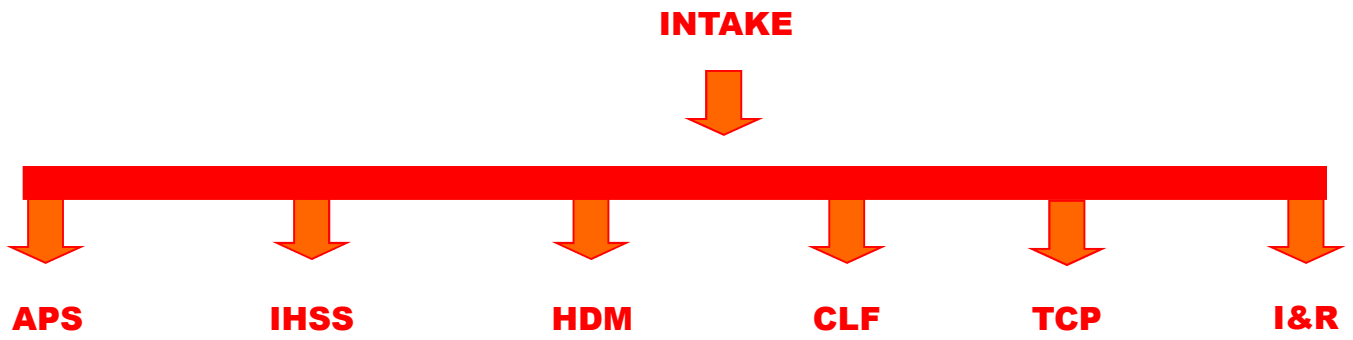
Mary Cabarles
Intake & Screening Unit

Mission Statement

The Department of Aging and Adult Services (DAAS) coordinates services to older adults, adults with disabilities and their families to maximize self-sufficiency, safety, health and independence so that they can remain living in the community for as long as possible and maintain the highest quality of life.

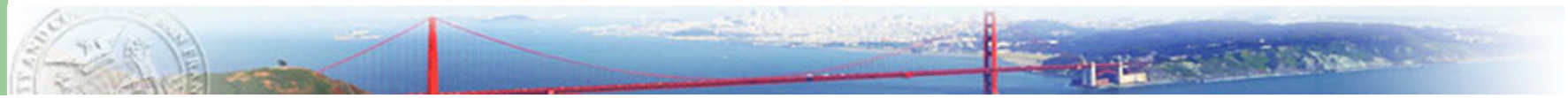


The Integration Concept



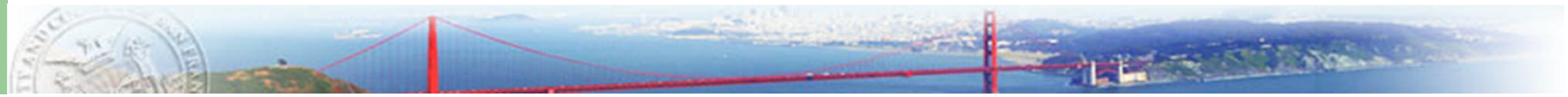
Adult Protective Services

- Investigates possible abuse or neglect.
- Services are voluntary; the adult who is offered the services must consent to receive them.



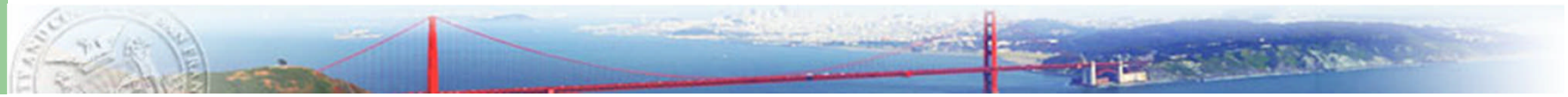
Goal

- To maintain the health and safety of elders and dependent adults in the community in the least restrictive environment.



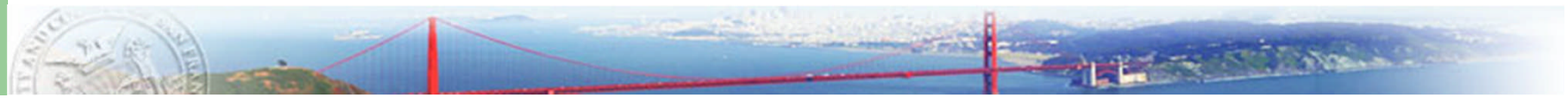
Statistics

- About 5% of the elderly are victims of abuse/neglect
- Severely underreported (1 in 5 to 1 in 15)
- About 50% is Self-Neglect
- 30% is Financial Abuse
- 2/3 of victims are women
- 90% of abusers are family members
- 1/3 of abusers are over 60 years old



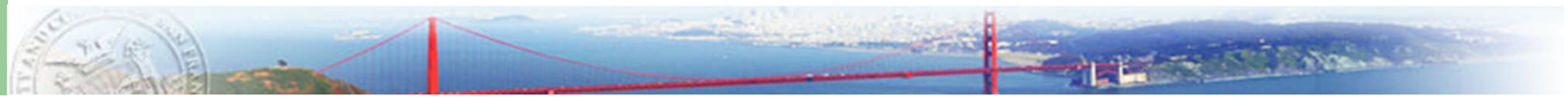
Client Profile

- Elder:
  - 65 years of age or older
- Dependent Adult:
  - Any person between the ages of 18 and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights



Reporters

- Mandated:
  - Any person who has assumed full or intermittent responsibility for the care or custody of a client, paid or unpaid
- Non-mandated/Voluntary:
  - Examples: Family, Friends, Neighbors

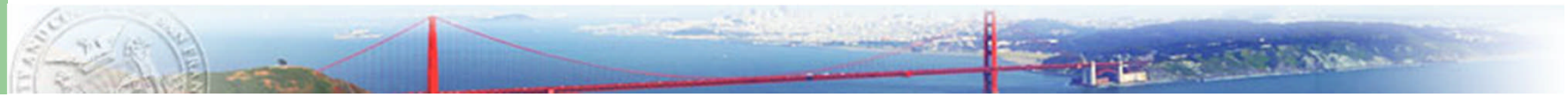


Types of Abuse

Mandated:

- Physical and Sexual Abuse
- Financial Abuse – undue influence
- Isolation
- Abduction/Abandonment
- Neglect By Others
- Self-Neglect

- Mental Suffering (not required, but encouraged)



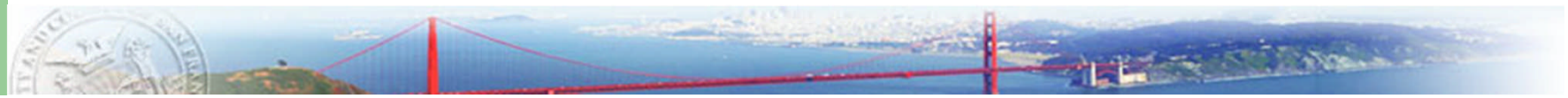
Services

Dual Role: Investigator & Social Worker

Brief Crisis Intervention:

- Emergency Response
- Emergency Services
- Emergency Fund for Support Services

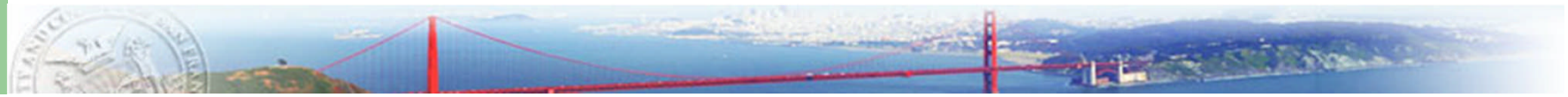
Short-term Counseling/Case Management



Referral Process

- CALL intake which is 24/7

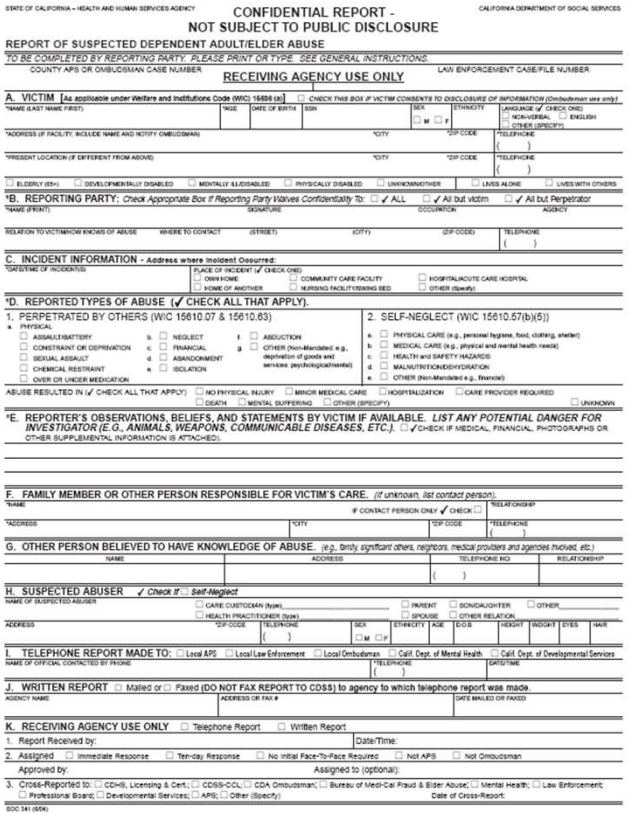
- Provide as much detail as possible
  - Physical description
  - Financial information
  - Household Composition
  - Collateral Contacts
  - Medical/Psychological History
  - Timeline of decompensation, situation, and/or relationship to abuser
  - Safety issues



SOC 341 – Report of Suspected Dependent Adult/Elder Abuse

- Complete as supplemental documentation.
- This form should not be sent prior to phone assessment.

http://www.sfhsa.org/asset/AgingandAdultServicesCommission/Form_SOC341.pdf



STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY — CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

COUNTY APS OR OMBUDSMAN CASE NUMBER — RECEIVING AGENCY USE ONLY — LAW ENFORCEMENT CASE/FILE NUMBER

A. VICTIM (As applicable under Welfare and Institutions Code (WIC) 15656 (a)) ☐ CHECK THIS BOX IF VICTIM CONSENTS TO DISCLOSURE OF INFORMATION (Ombudsman use only)

*NAME (LAST NAME FIRST) | *AGE | DATE OF BIRTH | SSN | SEX ☐ M ☐ F | ETHNICITY | LANGUAGE ✓ CHECK ONE: ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN) | *CITY | *ZIP CODE | *TELEPHONE ( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | *CITY | *ZIP CODE | *TELEPHONE ( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

*B. REPORTING PARTY: *Check Appropriate Box If Reporting Party Waives Confidentiality To:* ☐ ✓ ALL ☐ ✓ All but victim ☐ ✓ All but Perpetrator

*NAME (PRINT) | SIGNATURE | OCCUPATION | AGENCY

RELATION TO VICTIM/HOW KNOWS OF ABUSE | WHERE TO CONTACT | (STREET) | (CITY) | (ZIP CODE) | TELEPHONE ( )

C. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S) | PLACE OF INCIDENT (✓ CHECK ONE): ☐ OWN HOME ☐ HOME OF ANOTHER ☐ COMMUNITY CARE FACILITY ☐ NURSING FACILITY/SWING BED ☐ HOSPITAL/ACUTE CARE HOSPITAL ☐ OTHER (Specify)

*D. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL: ☐ ASSAULT/BATTERY ☐ CONSTRAINT OR DEPRIVATION ☐ SEXUAL ASSAULT ☐ CHEMICAL RESTRAINT ☐ OVER OR UNDER MEDICATION
b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

*E. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (E.G., ANIMALS, WEAPONS, COMMUNICABLE DISEASES, ETC.).* ☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED):

F. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME | IF CONTACT PERSON ONLY ✓ CHECK ☐ | *RELATIONSHIP

*ADDRESS | *CITY | *ZIP CODE | *TELEPHONE ( )

G. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(e.g., family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME | ADDRESS | TELEPHONE NO. | RELATIONSHIP

H. SUSPECTED ABUSER ✓ *Check If ☐ Self-Neglect*

NAME OF SUSPECTED ABUSER | ☐ CARE CUSTODIAN (type)_____ ☐ HEALTH PRACTITIONER (type)_____ | ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____ ☐ SPOUSE ☐ OTHER RELATION

ADDRESS | *ZIP CODE | TELEPHONE ( ) | SEX ☐ M ☐ F | ETHNICITY | AGE | D.O.B. | HEIGHT | WEIGHT | EYES | HAIR

I. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE | *TELEPHONE ( ) | DATE/TIME

J. WRITTEN REPORT ☐ Mailed or ☐ Faxed (DO NOT FAX REPORT TO CDSS) to agency to which telephone report was made.

AGENCY NAME | ADDRESS OR FAX # | DATE MAILED OR FAXED

K. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: | Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

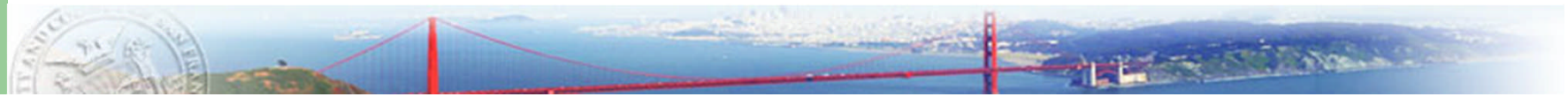
Approved by: | Assigned to (optional):

3. Cross-Reported to: ☐ CCHS, Licensing & Cert.; ☐ CCHS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) | Date of Cross-Report:

SOC 341 (5/04)

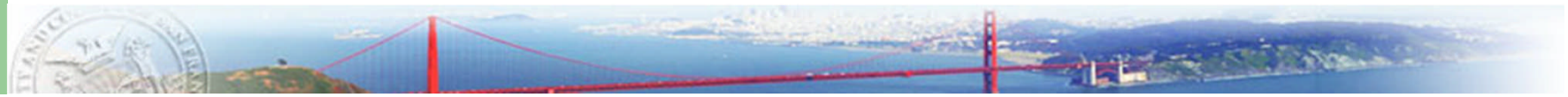
In Home Supportive Services

- Is designed to help low-income elderly, blind, and people with disabilities of all ages live safely in their own homes if they wish to do so, rather than in a nursing home or other facility.



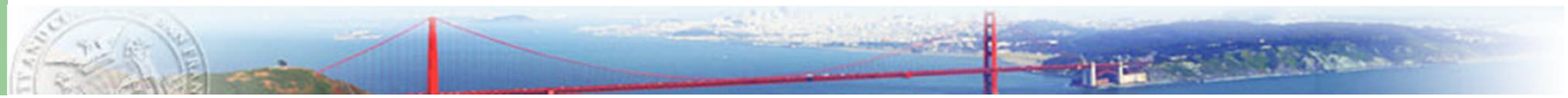
Services

- Household chores
  - Cleaning, Laundry, Shopping, Cooking, Washing Dishes
- Non-medical personal care
  - Bathing, Grooming, Feeding, Dressing or Toileting
- Paramedical services
- Transportation/Escort services



Eligibility

- Full-scope Medi-Cal
- For No Share of Cost:
  - Single: $1000/month income
    - Less than $2000 in liquid assets

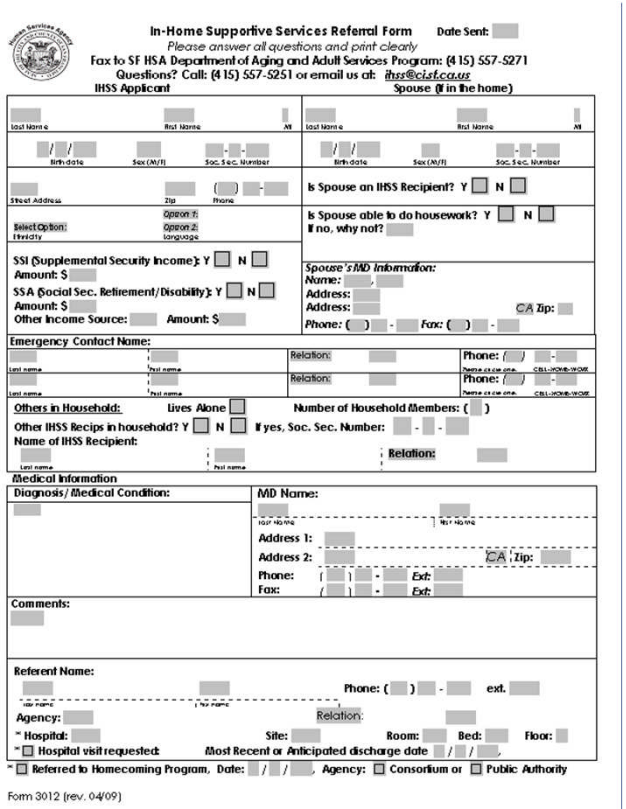


Referral Process

- Fill out 2 page form
- Fax to (415) 557-5271

OR

- Call hotline
- Information Needed:
  - SSN, DOB, Income, Medical Conditions, Primary Care Doctor, Recent Hospitalizations



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) 557-5251 or email us at: ihss@dcyf.ca.us

IHSS Applicant | Spouse (if in the home)

Last Name | First Name | MI | Last Name | First Name | MI

Birth date | Sex (M/F) | Soc. Sec. Number | Birth date | Sex (M/F) | Soc. Sec. Number

Street Address | Zip | Phone | Is Spouse an IHSS Recipient? Y N

Select Option: Ethnicity | Option 1: | Option 2: Language | Is Spouse able to do housework? Y N If no, why not?

SSI (Supplemental Security Income): Y N Amount: $

SSA (Social Sec. Retirement/Disability): Y N Amount: $

Other Income Source: Amount: $

Spouse's MD Information:

Name:

Address:

Address: CA Zip:

Phone: ( ) - Fax: ( ) -

Emergency Contact Name:

Last name | First name | Relation: | Phone: ( ) - Home or cell | CELL-HOME-WORK

Last name | First name | Relation: | Phone: ( ) - Home or cell | CELL-HOME-WORK

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

Other IHSS Recips in household? Y N 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 1:

Address 2: CA Zip:

Phone: ( ) - Ext:

Fax: ( ) - Ext:

Comments:

Referent Name:

Last Name | First Name | Phone: ( ) - ext.

Agency: Relation:

* Hospital: Site: Room: Bed: Floor:

* Hospital visit requested: Most Recent or Anticipated discharge date / /

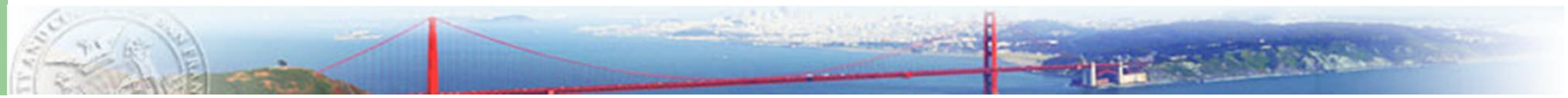
* Referred to Homecoming Program, Date: / / , Agency: Consortium or Public Authority

Form 3012 (rev. 04/09)

Home Delivered Meals

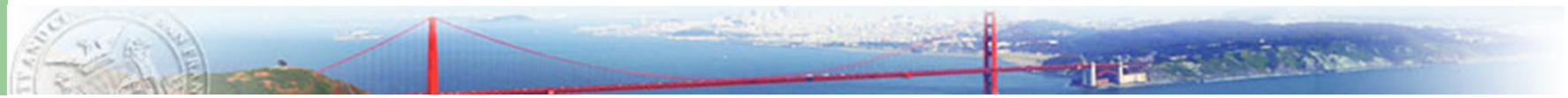
Eligibility:

- Age 60 and over
- Homebound by reason of illness, incapacitating disability, isolation, lack of social network and has no safe, healthy alternative for meals



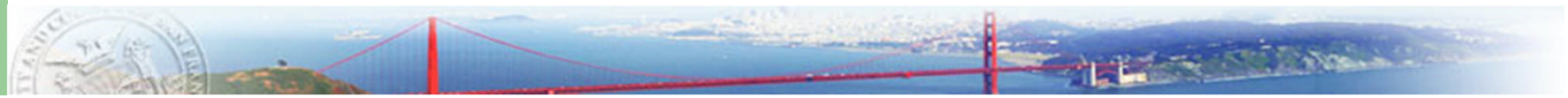
Referral Process

- CALL
- Phone assessment:
  - Allergies/Diet Type
  - ADLs/IADLs
  - Recent hospitalizations
  - Medical conditions
  - Environment including Appliances



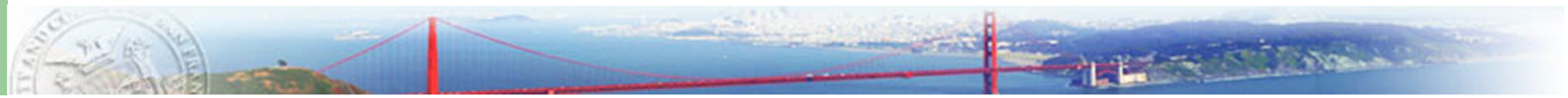
Community Living Fund

- Funds home and community-based services, or combination of goods and services, that will help individuals who are currently, or at risk of being, institutionalized or reinstitutionalized.



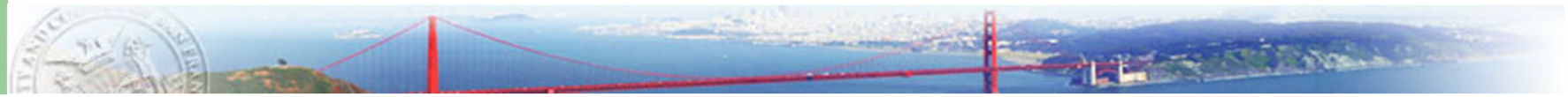
Services

- Coordinated case management
- Purchase of goods and/or services



Eligibility

- 18+ years
- Willing and able to live in the community with appropriate supports
- Income cannot exceed 300% of Federal poverty level
- Demonstrated need for a service and/or resource that will serve to prevent institutionalization



“Imminent Risk”

“At imminent risk” of being institutionalized:

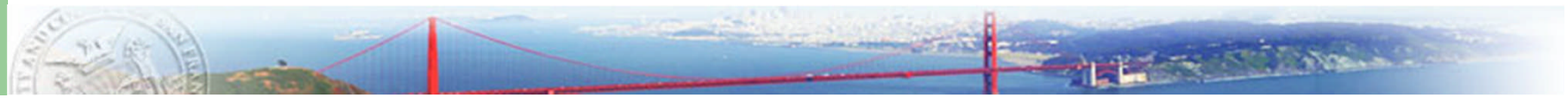
- Functional impairment in at least 2 Activities of Daily Living (ADL): Eating, Dressing, Transfer, Bathing, Toileting, Grooming

OR

- Function impairment in at least 3 Instrumental Activities of Daily Living (IADL) due to judgment, cognitive and/or mental health impairment: Taking Medication, Stair Climbing, Ambulation, Housekeeping, Laundry, Shopping, Meal Preparation, Transportation, Telephone Usage and Money Management

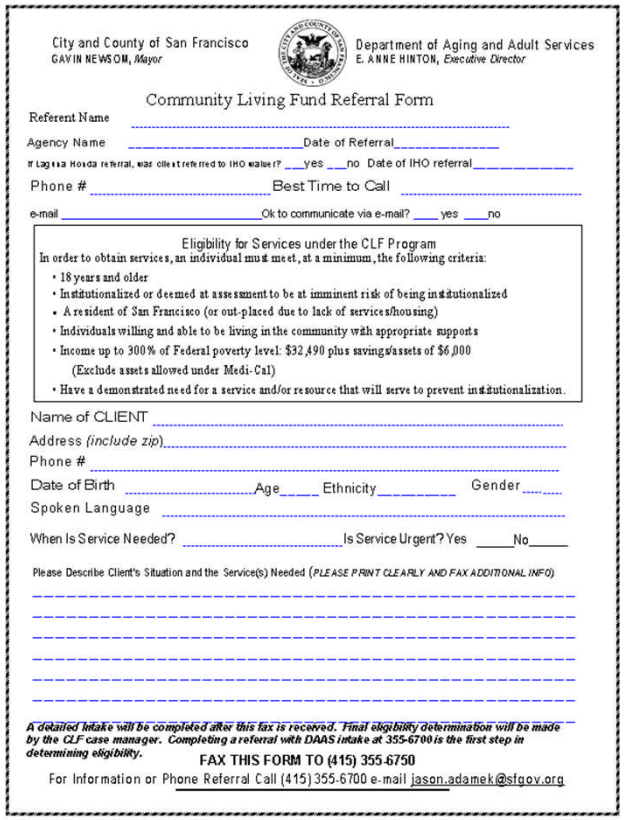
OR

- Medical condition requiring nursing facility level of care



Referral Process

- Fax Referral form OR Call
- Phone assessment
  - Current living situation
  - Recent hospitalizations/ placements at SNFs
  - Need for hospitalization
  - Functional Ability
  - Active/History of conditions
- Fund of last resort
  - Alternatives resources



City and County of San Francisco
GAVIN NEWSOM, *Mayor*

Department of Aging and Adult Services
E. ANNE HINTON, *Executive Director*

Community Living Fund Referral Form

Referent Name _____

Agency Name _____ Date of Referral_____

If Laguna Honda referral, was client referred to IHO waiver? ___yes ___no Date of IHO referral_____

Phone # _____ Best Time to Call _____

e-mail _____ Ok to communicate via e-mail? ___yes ___no

Eligibility for Services under the CLF Program

In order to obtain services, an individual must meet, at a minimum, the following criteria:

- 18 years and older
- Institutionalized or deemed at assessment to be at imminent risk of being institutionalized
- A resident of San Francisco (or out-placed due to lack of services/housing)
- Individuals willing and able to be living in the community with appropriate supports
- Income up to 300% of Federal poverty level: $32,490 plus savings/assets of $6,000 (Exclude assets allowed under Medi-Cal)
- Have a demonstrated need for a service and/or resource that will serve to prevent institutionalization.

Name of CLIENT _____

Address *(include zip)* _____

Phone # _____

Date of Birth _____ Age_____ Ethnicity_____ Gender_____

Spoken Language _____

When Is Service Needed? _____ Is Service Urgent? Yes _____No_____

Please Describe Client's Situation and the Service(s) Needed (*PLEASE PRINT CLEARLY AND FAX ADDITIONAL INFO*)

_____

_____

_____

_____

_____

_____

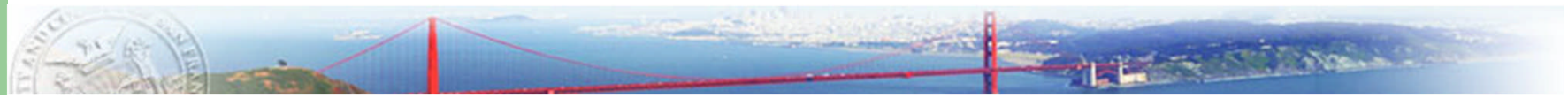
A detailed intake will be completed after this fax is received. Final eligibility determination will be made by the CLF case manager. Completing a referral with DAAS intake at 355-6700 is the first step in determining eligibility.

FAX THIS FORM TO (415) 355-6750

For Information or Phone Referral Call (415) 355-6700 e-mail jason.adamek@sfgov.org

Transitional Care Program

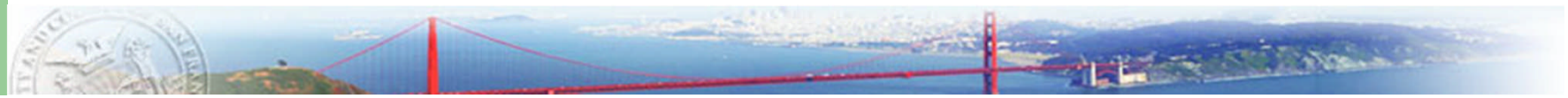
- Hospital-to-home service to bridge the gap between a hospital discharge and a strong recovery.
- 6 week consultation and service coordination
- Medicare A & B
- Referral completed by discharge planners



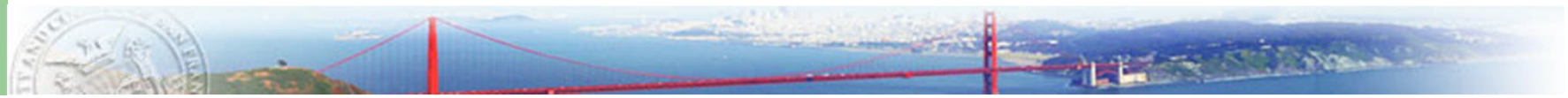
Information & Referral

Consultation for present and future services

- Regular
  - Direct Questions
- Short Term
  - Brief assessment plus 1 follow-up
- Long Term, Options Counseling
  - More complex cases, future services to consider
  - Action Plan

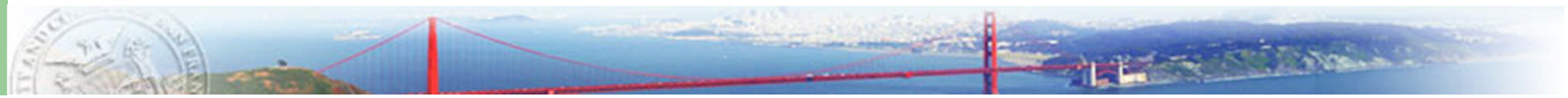


Other DAAS Programs



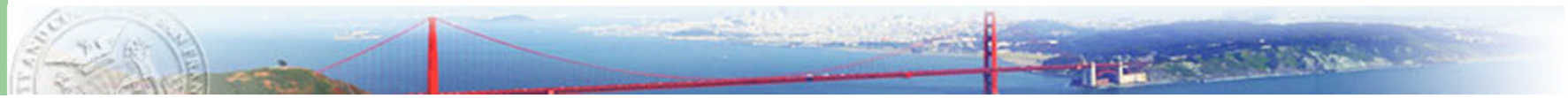
Office on the Aging

- Awards and manages contracts with community-based organizations and public agencies to provide a wide range of programs and services, such as nutrition programs, transportation, and senior centers, among others.



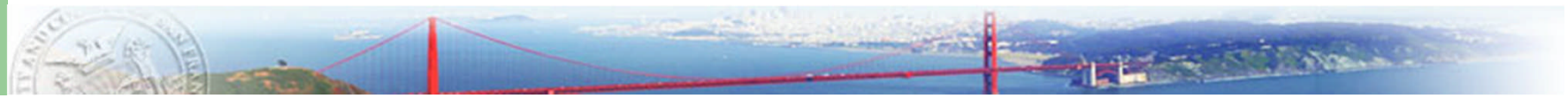
Public Guardian

- Provides probate conservatorship services for seniors and adults with disabilities who are substantially unable to provide for their own personal needs and/or are unable to manage finances or resist fraud or undue influence.



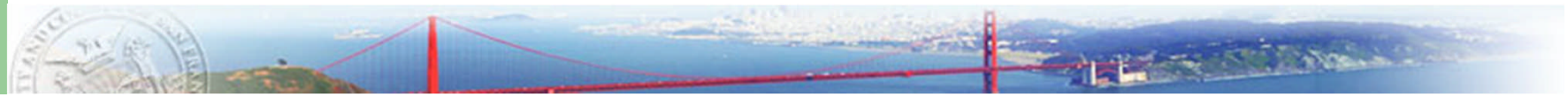
Public Conservator

- Provides mental health conservatorship services for San Francisco residents, who are gravely disabled (unable to provide for food, clothing, or shelter) due to mental illness and found by the Court unable or unwilling to accept voluntary treatment.



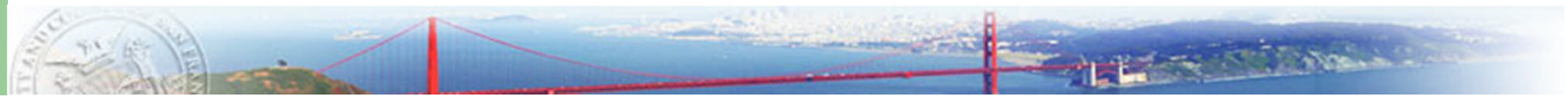
Public Administrator

- Administers the estates of deceased San Francisco residents when no family members are able or willing to act, when required by the California Probate Code and when appointed by the Superior Court.



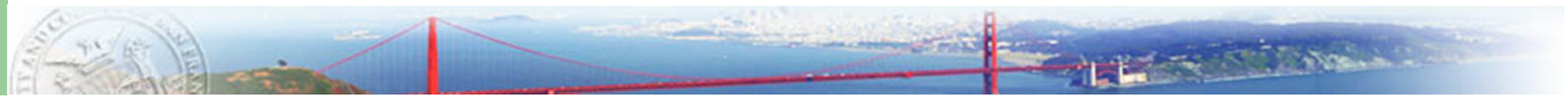
Representative Payee Program

- Manages money for adults and elderly individuals with physical and/or mental impairments who cannot manage their own funds.
- This program is voluntary and each participant must have a case manager to be eligible.



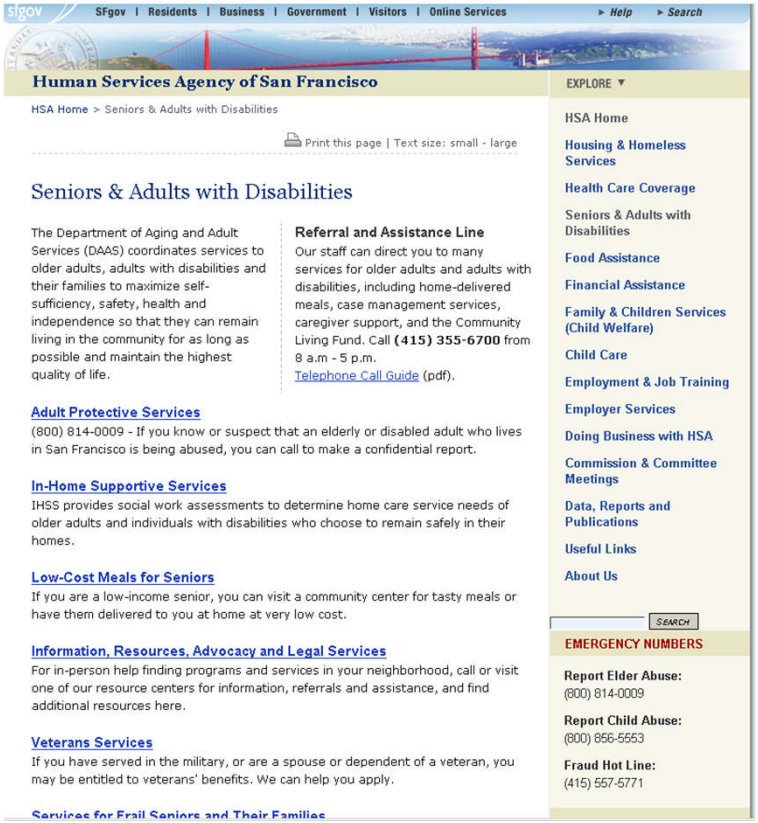
County Veterans Service Office

- Assists veterans, their dependents and survivors to obtain U.S. Department of Veterans Affairs' benefits and entitlements.
- Provides outreach and service to homeless veterans and veterans with disabilities.

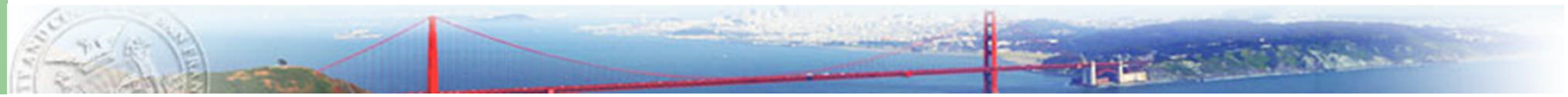


DAAS Website

http://www.sfhsa.org/DAAS.htm



Additional Resources



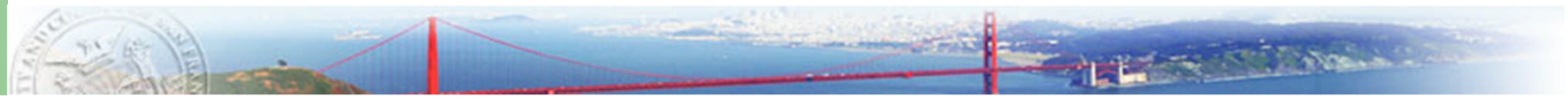
Aging & Disability Resource Center

Main Location: Canon Kip Senior Center

- Provides short term case management and information & referral.

Out stations:

Self Help for the Elderly
30th Street Senior Center
OMI Catholic Charities
Independent Living Resource Center
Bayview Hunters Point Multi-Purpose Senior Center
Visitacion Valley Senior Center
SF Senior Center – Downtown Branch
Kimochi
Sunset Senior Center
Stonestown YMCA
Curry Senior Center
Bayanihan



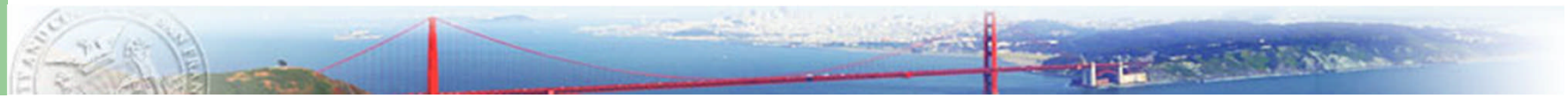
HICAP

Health Insurance Counseling & Advocacy Program

One-On-One Counseling to

Clarify, Compare & Evaluate

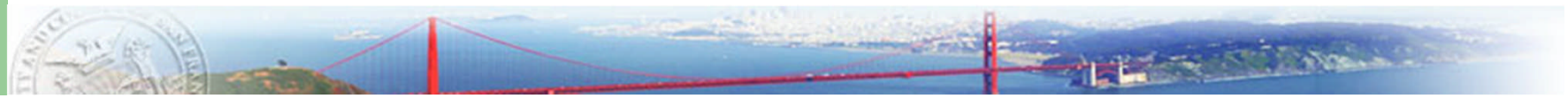
Medicare, Medicare Part D Plans, MediGap,
Medicare Advantage Plans, Long Term Care Insurance
& Medicare Billing

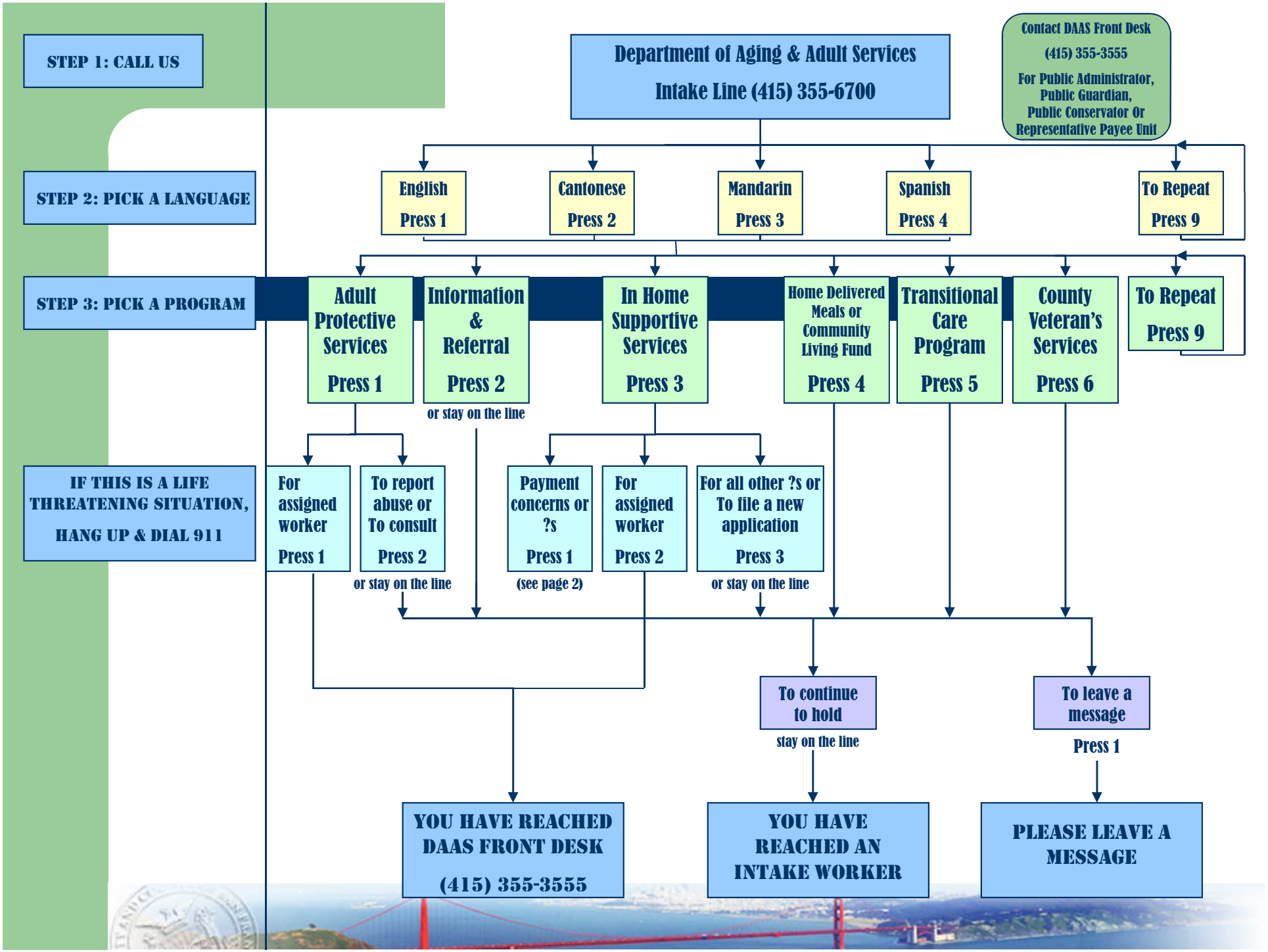


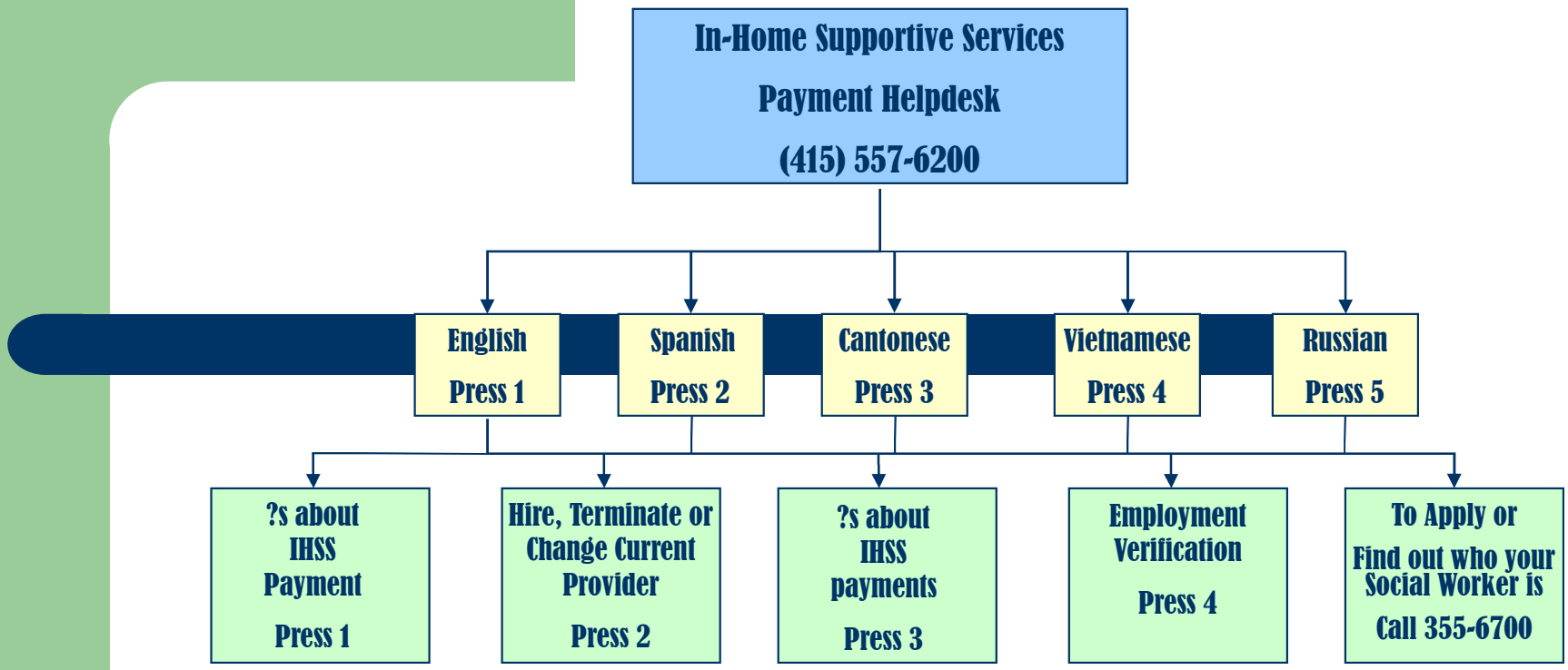
Contact Us

- Hotline (415) 355-6700
- Fax (415) 355-6750

- IHSS Fax (415) 557-5271




STEP 1: CALL US
Department of Aging & Adult Services
Intake Line (415) 355-6700
Contact DAAS Front Desk
(415) 355-3555
For Public Administrator, Public Guardian, Public Conservator Or Representative Payee Unit
STEP 2: PICK A LANGUAGE
English Press 1
Cantonese Press 2
Mandarin Press 3
Spanish Press 4
To Repeat Press 9
STEP 3: PICK A PROGRAM
Adult Protective Services Press 1
Information & Referral Press 2
or stay on the line
In Home Supportive Services Press 3
Home Delivered Meals or Community Living Fund Press 4
Transitional Care Program Press 5
County Veteran's Services Press 6
To Repeat Press 9
IF THIS IS A LIFE THREATENING SITUATION, HANG UP & DIAL 911
For assigned worker Press 1
To report abuse or To consult Press 2
or stay on the line
Payment concerns or ?s Press 1
(see page 2)
For assigned worker Press 2
For all other ?s or To file a new application Press 3
or stay on the line
To continue to hold
stay on the line
To leave a message
Press 1
YOU HAVE REACHED DAAS FRONT DESK
(415) 355-3555
YOU HAVE REACHED AN INTAKE WORKER
PLEASE LEAVE A MESSAGE


In-Home Supportive Services
Payment Helpdesk
(415) 557-6200
English
Press 1
Spanish
Press 2
Cantonese
Press 3
Vietnamese
Press 4
Russian
Press 5
?s about IHSS Payment
Press 1
Hire, Terminate or Change Current Provider
Press 2
?s about IHSS payments
Press 3
Employment Verification
Press 4
To Apply or
Find out who your Social Worker is
Call 355-6700