



Gender Health SF: Surgery Aftercare Referrals

Gender Health SF developed the following list of available resources that patients will likely need as they access gender affirming surgeries through Gender Health SF Surgery Access Program. At this time GHSF cannot provide direct clinical case management to assist with these referrals. Please note that the referrals are time sensitive and are not automatically initiated by the surgeon or hospital. In addition, many of them specifically need to be initiated by the primary care clinic and provider. It is recommended that primary care clinic staff coordinate these referrals for their patients.

Referrals to Consider for Patients

Health at Home (in home nursing care)

Service Summary:

- Skilled nursing provided in patients' residence. Visit frequency depends on assigned nurse's assessment of patient needs. Typically 2 x a week.
- Wound care, medical supplies, physical needs assessment, medical advice, medication assistance.
- Encourage patient to ask for additional supplies from assigned nursing staff, if needed.

Referral Process

- Referral initiated through LCR eReferral under "Other Programs"
- Referrals can be initiated **2 weeks in advance** of anticipated discharge date
- If you have any issues with eReferral for Health at Home, call (415) 759-4700.

Project Open Hand (Food Access/Delivery)

Service Summary:

- One hot meal delivery 1 x day, 7 meals per week, duration of 6 weeks post-surgery.
- Patients can opt for bland, vegetarian, diabetic, mechanically soft, and regular meals
- Ask about getting 1 week of prepared frozen meals ahead of time and pick up frozen meals weekly during recovery. Patient can identify a "surrogate shopper" to assist with meal pick up if needed.

Referral Process:

- Completed Project Open Hand Application found at: <https://www.openhand.org/documents/poh-client-application-sep-2018> . Form to be completed by medical provider (MD or NP), or medical social worker.
- Form can be submitted **2 weeks** before meals will be needed.



In-Home Support Services (IHSS)

Service Summary:

- Patients who have Medi-cal typically have access to IHSS services that help individuals with grooming, food preparation, household chores/laundry, medication/medical supply pick-ups, grocery shopping, and errands.
- Patient with Healthy SF can receive 2 weeks of service.
- The IHSS social worker assigned to a Patient will assess needs and hours given. After referral is completed you can call #415-557-5251 to find out who assigned social worker is.
- Applications to apply & medical form SOC 873 (PCP fills out) can be found at:
<https://www.sfhsa.org/services/care-support/home-supportive-services-ihss/receive-home-services/become-ihss-care-recipient>

Referral Process:

- Requires the completion of two forms: Intake Form 3012 and Medical Form SOC873, both forms are attached in this packet. You can also call and do an intake over the phone #415-355-6700.
- Forms can be submitted only upon admission for surgery, unless patient already meets disabling requirements for receiving IHSS services.
- Expedited service requires selecting “Emergency on Call Requested” on the Form 3012. Reason for emergency need could include, “patient lives alone” or “patient without support person”.
- Form 873 must be completed by a licensed medical provider and requires the patient’s signature.
- It is recommended that you let the intake person know that Patient will need to go through Homebridge if they do not have an Independent Provider (IP mode) in mind or set up. IP workers have to be approved by IHSS and there is an application process. Please apply for IHSS service in enough advance if needed as intakes can take up to 2-6 weeks to happen due to impacted system of care.

Medical Transport Service (SFHP only)

Service Summary:

- Patient is eligible for 3 free post-operative taxi rides to and from the surgeon office for follow up visits.
- **Semax** is designated as the medical transportation vendor # 415-285-6945
- Patient will need to call 2 hours before appointment time to confirm scheduled pick up. If any appointment date/time is changed Semax will need 24-hour notice.
- Patient will need to discuss return ride home with appointment set up.

Referral Process:

- Primary Care Provider to complete and submit *Transportation Request Form* to Semax between 4-6 weeks before surgery.
 - Include any scheduled follow up appointment dates/times on request form.
 - Submit letter of medical necessity for transportation with request form.
- Semax will submit Prior Authorization to SFHP



Paratransit Transportation Service

Service Summary:

- Patients may be dropped off 60 minutes before scheduled appointment and may need to wait 30-60 minutes after appointment for pick up.
- Some Patients *may be eligible for discounted taxi script* versus van service through SF Paratransit Taxi service. Please further inquire around taxi service, and a patients need to access taxi versus van service.
- Application is found here: <https://www.sfparatransit.com/docs/ADA-Application-Rev-2-2019-FINAL.pdf>
- **To reserve ride:** patient calls scheduling line between 1 – 7 days before appointment
- For Patient needing rides within SF
 - Scheduling line is 415-285-6925 (open 7AM-6PM for scheduling)
 - Ride Cost \$2.50
- For patients needing rides to BCSS office in Greenbrae:
 - Address is: 575 Sir Francis Drake Blvd
 - Marin Paratransit will transport people from SF to Marin and back. Depending on patient’s address, may need to wait at a bus stop for van.
 - Referring provider needs to make sure patients’ eligibility for services is faxed from the SF office to Marin.
 - Marin Paratransit Scheduling line is open 8AM-5PM: 415-454-0964
 - Ask about total cost of round trip ride ~ around \$20. Patient will not need to pay initial activation for van access card, if not using services within SF.
- For patients needing rides to Dr. Bowers in Burlingame:
 - Address is: 345 Lorton Ave, Suite 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 8:30AM-5PM: 650-560-0360.
 - Total Cost: \$2.50 to SF Paratransit to Stonestown + \$4.25 one way trip to San Mateo Redi-Wheels (Stonestown to San Mateo)

Referral Process:

- Fill out SF Paratransit application at least 21 days in advance
- Potential case for taxi script service, important to site “safety concerns” or “difficulty riding bus due tomedical issues, mental distress, etc.”

Post-Surgical Supplies

Covered Medical Supplies		
Vaginoplasty	Phalloplasty	Metoidioplasty
Maxi Pads (liners)	Diapers (disposable briefs)	Diapers (disposable briefs)



Diapers (disposable briefs)	Chux (disposable underpad)	Chux (disposable underpad)
Chux (disposable underpad)	Xeroform Gauze (5"x9")	
Water-based Lubricant (Reliagel)		
Antibiotics (Surgeon Rx)	Antibiotics (Surgeon Rx)	Antibiotics (Surgeon Rx)
Pain Meds (Surgeon Rx)	Pain Meds (Surgeon Rx)	Pain Meds (Surgeon Rx)
Dilators (Surgeon distributes)	Colace, stool softener	Colace, stool softener
Colace, stool softener	Acetaminophen	Acetaminophen
Acetaminophen		
Metrogel (Dr. Bowers only)		
Other Medical Supplies to consider (may not be covered)		
Facial Feminization Surgery		
Ensure/nutrition shakes		
Straws		

Vendor Summary

- **For patients with SFHP:**
 - Vendor is *Sincere Care* , **Phone:** 415-752-3288, **Fax:** 415-759-8900
 - To Order:
 - Complete and fax incontinence supply form (see Attached). There is a maximum monthly allowance and supplies will need to be re-ordered each month.
 - In the "order" column, write the number that appears in the "monthly usage" column for that item.
 - For all other supplies, Primary Care Provider will need to fax in a script with the required supply, diagnostic code, and procedure. Please also include in the faxed request the patient name, DOB, address, phone number and insurance.
 - Vendor delivers supplies directly to patient's residence or clinic.

- **For patients with Anthem Blue Cross Medi-cal:**
 - Vendor is *Shield*, **Phone:** 1-800-675-8840, **Fax:** 925-256-1639
 - To order:



- Primary Care Provider will need to fax in a script with a required supply, diagnostic code, and procedure. Please also include in the faxed request the patient name, DOB, address, phone number, and insurance.
- Vendor delivers supplies directly to patient's residence or clinic.
- For patients with Healthy SF, supplies cannot be ordered for individual patients from an outside vendor. Please work with your primary care clinic to see if clinic can order supplies to distribute to patient.

ReCares is a possible resources as well for Medical Supplies. They provide free medical supplies to patients in need in San Francisco, Oakland, and Marin that come through donations.

- Oakland : Phone 510-251-2273 – Entrance via Garage behind the church on 27th St
2619 Broadway, Oakland, Ca 94612 (in parking lot behind 2619 Broadway)
Distribution Days: Fridays 12pm-4pm
- San Francisco: Phone 415-487-5405
Dorland Street (The alleyway of 63 Dorland), San Francisco, CA 94110
Distribution Days: Thursdays 10am – 3pm
- Marin County: Phone 415-388-8198
3100 Kerner Blvd, San Rafael, CA 94901
Distribution Days: Wednesdays 11am – 2p m
- Please visit <https://www.homecares.org/> to view more information regarding medical supplies available.

REFERRED BY: _____ PHONE: _____ FAX: _____

PROJECT OPEN HAND

730 Polk Street, San Francisco, CA 94109 415/447-2326 Fax: 415/429-3852
1921 San Pablo Avenue, Oakland, CA 94612 510/622-0221 Fax: 510/452-1061



Project Open Hand
meals with love

Application for Services (6 month duration; subject to eligibility)

1. Consent to release information:

I authorize my medical providers and referring party to release information about my medical condition to Project Open Hand for purposes of verifying my eligibility. I also authorize Project Open Hand to discuss the terms of my eligibility and/or services with my medical providers and referring party.

Patient Name: _____ Date of Birth: _____ Phone: _____
Patient Signature: _____ Date: _____ County: _____

Healthcare Provider only below this line

2. PHYSICAL DATA: (Must be current within six months)

Height: _____ ft. _____ in. Usual weight: _____ lbs. Blood pressure: _____ / _____
Current weight: _____ lbs. Weight change over: _____ months Date: _____

3a. PRIMARY DIAGNOSIS and CLINICAL DATA: (Check all that apply; data must be current within six months)

- NO PRIMARY DIAGNOSIS
- HIV+/AIDS
- Cancer, active diagnosis
Type: _____ Stage: _____
Date of most recent diagnosis: _____
- Active Treatments: (check those that apply)
 - Radiation therapy Chemotherapy
 - Hormone therapy Not receiving treatment
- Diabetes
 Type 1 or Type 2 (check one)
HbA1c: _____ Date: _____
- End stage Renal Disease (ESRD)
Creatinine: _____ BUN: _____ Date: _____
- End Stage Liver Disease (ESLD)
- Cardiovascular disease (check those that apply)
 - Congestive Heart Failure (CHF) NYHA Class: _____
 - Coronary Artery Disease
 - Total cholesterol: _____ HDL / LDL: _____ / _____
 - Triglycerides: _____ Date: _____
- Chronic Obstructive Pulmonary Disease (COPD)
Stage: _____ FEV1: _____ Date: _____
- Autoimmune disease (e.g. Lupus)
- Hepatitis B, chronic or Hepatitis C (check those that apply)
- Serious Neurologic Condition (check those that apply)
 - Stroke Parkinson's
 - Multiple Sclerosis ALS (Lou Gehrig's disease)
- Trauma/major surgery, within 30 days of discharge (6 week service)
Type: _____ Discharge date: _____

3b. CONCOMITANT DIAGNOSES: (Check any exhibited in the past 30 days)

- Opportunistic infection, inhibiting ability to access and/or prepare meals - Describe: _____
- Anemia Hypertension Hyperlipidemia

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

- NO SYMPTOMS
- Chronic (>30 days), inhibits normal daily functioning: (check those that apply) Intractable diarrhea Nausea Vomiting
- Unintentional weight loss of more than 5% of baseline body weight in 1 month or 10% in 6 months
- Inability to gain weight if underweight (BMI < 18.5)
- Oral conditions preventing adequate nutritional intake
- Muscle weakness in one or more of the following areas: hands, arms or legs, or the muscles of speech or breathing
- Difficulty standing and/or ambulation due to: (check those that apply) Twitching (fasciculation) Numbness Tingling Cramping of muscles
- Edema, or other severe swelling in ankles or feet
- Difficulty swallowing (dysphagia)
- Fatigue: (check one) Mild Moderate Severe
- Shortness of breath at rest: (check one) Mild Moderate Severe
- Mild diarrhea Mild wasting Severe pain Lymphedema Spasticity Ataxia Slow-healing sores

Signature of Provider _____ Printed Name of Provider _____ Office Stamp _____ Address, Phone and Fax _____ Date _____

V061715

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



Project Open Hand
meals with love

Application for Services (6 month duration; subject to eligibility)

Patient Name: _____

5. OTHER FACTORS: (Check any exhibited in the past 30 days)

- Dementia
- Hospice or palliative care
- Homeless or marginally housed
- Substance use

Describe: _____

- Mental illness

DSM V diagnosis: _____

- Cognitive deficit

Describe: _____

- Developmental disability

Describe: _____

6. DELIVERY SERVICES: (Available to clients with restricted mobility residing in San Francisco and Oakland)

- PATIENT IS ABLE TO PICK UP MEALS or PATIENT HAS SUPPORT PERSON TO PICK UP MEALS**

- 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 patient prepare/cook food
- Leaving home may create safety risk or hardship

7. NUTRITION SERVICES: (Available to all clients)

- Consult with patient's existing dietitian: Name - _____ Phone - _____

- Refer patient to Project Open Hand registered dietitian: (list labs, relevant medical history, medications, surgeries, or other information)



In-Home Supportive Services Referral Form
 Fax to SF HSA Department of Aging and Adult Services Program: (415) 557-5271
Questions? Call: (415) 355-6700 or email us at: ihss@sfgov.org
 Please answer all questions and print clearly

IHSS Applicant

Date Sent: / /

Last Name	First Name	MI	Social Security Number	Birth Date
Street Address	Apt#	Zip	() - Phone	Email
What is your gender: (one that best describes your current gender identity) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male <input type="checkbox"/> Trans Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not listed. Please specify:				
What was your sex at birth? (one that indicates your sex at birth) <input type="checkbox"/> Male <input type="checkbox"/> Female				
How do you describe your sexual orientation or sexual identity? (indicate one that best describes your sexual orientation) <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not listed. Please specify: <input type="checkbox"/> Decline to answer				
Ethnicity:		Language(s):		
Does applicant receive Supplement Security Income (SSI)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Is the applicant enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

Referent Information

***For non self-referrals, please attach applicant's signature of Authorization for Release of Information**

Referent Name:	Relationship to Applicant:
Phone: () - Ext:	Agency/Organization:

Residence/Discharge Information

Living Situation: Lives Alone? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of others in household:
Household members' relationship to client: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Adult Child <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-relative	
The client is currently: <input type="checkbox"/> At Home/At an Alternative Address <input type="checkbox"/> Hospitalized - Target Discharge Date: / / Was client discharged from facility within the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: / /	
Hospital:	Campus/Site: Room: Bed: Floor:

Spouse/Other IHSS Recipient

Is the client married? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown *If yes, please answer the following questions about the spouse (if in the home).				
Last Name	First Name	MI	Social Security Number	Birth Date
Is the spouse an IHSS Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is the spouse able to do housework? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?				
Spouse's Doctor Information				
Name:	Address:	City:	Zip:	
Phone: () -	Fax: () -	Email:		
Other IHSS recipients in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, IHSS Recipient's Name: Social Security Number: - - Relation:				

Emergency On-Call Home Care

Is emergency on-call home care requested? Yes No

**Please note: DAAS is unable to authorize "ER" on-call IHSS services without a completed health care certification form SOC 873. Please fax this form to DAAS Intake at (415) 557-5271.*

If yes, why are emergency services needed?

How will service needs be met until IHSS eligibility and services are established?

Applicant's Physician/Clinic Information

Name:		Specialty:	
Last Name	First Name		
Address:			
Street Address	City	State	Zip
() - Phone Number	() - Fax		Email

Medical and/or Mental Health Information

Diagnosis/Medical Condition (please explain)

Additional Comments

Emergency Contact Information

Last Name	First Name	Relation	() - Phone Number
Last Name	First Name	Relation	() - Phone Number

The following information will help us assess your needs and respond to your request for services. If the form is not completed in full, you will be contacted for more information.

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	Not Active	Past History	Unknown	Explain (If Active or Past History)
Violent Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Financial management/Eviction	<input type="checkbox"/>	<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.

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, _____, (PRINT NAME), 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: _____

(APPLICANT/RECIPIENT OR LEGAL GUARDIAN/CONSERVATOR)

Date: ____/____/____

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 OR expected to result in death within 12 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 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
Compact Disc/CDR

Call: (415) 351-7000

Если вы хотите иметь это заявление на русском языке, пожалуйста, позвоните по телефону (415) 351-7006

Si usted desea tener esta solicitud en español, por favor llame al (415) 351-7004

如果您想使用中文申請, 請致電 (415) 351-7005

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 three places to complete the application:**
 - Applicant Certification (Page 8)
 - Authorization to Release Information for an appropriate medical or rehabilitation professional (Pages 9 and 10)
4. **Return the completed application to:**
Mail: 68 – 12th Street, San Francisco, CA 94103
Fax: (415) 351-3135
Email: sfptcertification@sfparatransit.com

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

Thank you

Please Print

Personal/Contact Information

Name (first, middle, last):

_____ E-Mail: _____

Home Address: _____ Apt. #: _____

City: _____ Zip: _____

Mailing Address (if different from home):

_____ Apt. #: _____

City: _____ Zip: _____

Daytime Phone: (____) _____ TDD/TTY: (____) _____

Evening Phone: (____) _____ Cell Phone: (____) _____

Would you be interested in receiving messages via text messaging?

___ yes ___ no

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:

CD/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 _____

Is there someone (e.g., relative, social worker or agency, etc.) that you would like us to notify 90 days before your eligibility expires?

Yes No

If yes, Person's Name/Agency:

Email address: _____ Phone: (____) _____

Relationship: _____

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 be filled out by applicant or applicant's representative)

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 Veolia/SF 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.)

SEMAX TRANSPORTATION

Non-Emergency Medical Transportation
Tel: 415-439-9836 , Fax: 888-315-5419

TRANSPORTATION REQUEST FORM

FACILITY NAME: _____	Date of Service : _____	Appointment Time: _____
Address: _____	Pick-Up Time _____	Return Pick-Up Time _____
	FOR MULTIPLE TRIPS:	
Person filling request: _____	_____ Times per week for _____ week's, months	
	Date of Service : _____	Appointment Time: _____
Phone: _____ Fax: _____	Pick-Up Time _____	Return Pick-Up Time _____

RESIDENT INFORMATION:

Last Name _____

First Name _____

DOB: _____ Gender: M F

Pick-Up address: _____

Contact Number _____

Diagnosis: _____

Purpose of Visit: _____

Appointment or Drop-Off Address: _____

INSURANCE INFORMATION:

Medical ID # _____

Other: _____

Patient is unable to use public/private transportation due to:

PHYSICAL LIMITATION:

- Amputee
- Blind
- Cannot transfer w/o Assistance
- Fall Risk

- Mobility problem
- Morbid Obesity
- Wheelchair Bound
- Other: _____

OTHER REQUEST:

- Wheelchair
- Gurney (requires Assistance)
- With Oxygen

PATIENT IS GEN. WEAKNESS, CANNOT USE PUBLIC AND PRIVATE TRANSPORT, DIFFICULTY AMBULANCE DISTANCE, FOR ALL TRANSFERS TO ENSURE PT'S SAFETY REQUIRE ASSISTANCE TO MAINTAIN LIFE-SUSTAINING TREATMENT

Doctor's name: _____

Doctor's License # _____

Doctor's Signature _____

Address: _____

Tel: _____



ReCARES ReDISTRIBUTES wheelchairs, walkers plus other medical equipment and supplies for FREE!

***WHERE: 63 Dorland Street, San Francisco CA 94110
(Alleyway at 63 Dorland)***

WHEN: Every Thursday: 10 AM to 1 PM

PLEASE VISIT US IF YOU NEED ANY OF THESE

- Wheelchair
 - Walker
 - Cane
 - Briefs
 - Shower Chair
 - Tub Transfer Bench
 - Chux (Disposable Bed Pads)
 - And *More...*

If you HAVE any of these items you NO LONGER NEED please bring them to us. *We are a 501(c)3 tax exempt charitable organization.*

If you have or need a Power Wheelchair, Hospital Bed or Stair Lift, call us and leave your phone number!

Phone: 415-487-5405

Leave a message and your call will be returned.

Internet: ReCARES.org



健誠 醫療器材

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

Sincere Care Medical Supply

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 (X) Both

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

302.85

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

4. Type of Bowel incontinence: () Nervous System Pathology (X) 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
			T4525	4	110	1320
	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/xxxx]**, Insurance Plan **[Name]**: **[MEMBER ID #, if available]** 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 (4 oz. each.)

Sincerely,

Physician's Name

Certificate Number

Address

Telephone

Fax