Whole Person Care Program Referral Form

Phone: (831) 638-3383 Fax: (831) 634-0785 Email: wpcsbc@cosb.us

Whole Person Care
Pathway to Independence and Wellness
California Small County Collaborative

Referred By

Name: _____ *Agency:* _____

Phone: _____ *Fax:* _____ *Email:* _____

"I, _____ *(name), have been told about the Whole Person Care program by* _____ *(referring person or entity) and would like to be referred and receive more information from the Whole Person Care program."*

Client Information

First Name: _____ *Middle:* _____ *Last:* _____

Preferred Name: _____ *Gender (Circle one): M F O*

Address Or best location to reach client: _____

_____

Primary Phone: _____ *Secondary Phone:* _____

E-mail Address: _____ *Preferred Language:* _____

Please attach copy of Photo ID & Medi-Cal Card (if obtainable)

Eligibility

Following are the criteria on which we will determine the client's eligibility. Check all that apply to this Client:

☐ **Person age 18-64**

AND

☐ **A Medi-Cal beneficiary or Medi-Cal eligible**

AND

☐ **Homeless or at risk of Homelessness**

AND

Meets 1 or more of the characteristics listed below:

☐ Mental Illness

☐ Substance Abuse Disorder

☐ Two (2) or more chronic health diagnoses

☐ Emergency department visits and/or at least one hospitalization in the past 6 months

☐1 ☐2 ☐3 ☐4 ☐ >4

☐Involved with the criminal justice system

Internal Use Only: WPC# _____ **Medi-Cal ID:** _____ **Date Received:** _____

Status: Eligible / NOT Eligible Circle: New /Previous/Existing Client Referral Source Contact Date: _____

Comments: _____