801 Gateway Boulevard, Suite 100
South San Francisco, California 94080

Community-Based Adult Services (CBAS) Referral Form

Date: ______________________________

Member's Name: ________________________________		Phone (Best Contact): ____________________
Member's Address: (Street, Apt, City, State, Zip) ________________________________		Primary Language: ____________________
Member's Date of Birth: ____________________	HPSM ID or Medi-Cal ID (CIN): ____________________	Interpreter Required? ☐ Yes ☐ No
Name of Appointed Representative: ____________________	Relationship to Member: ____________________	If yes, what is member's preferred language? ____________________
Appointed Representative's Phone: ____________________		

Member was informed of this referral: ☐ Yes ☐ No

CBAS Center Requested by Member: ________________________________

Medical CBAS Reason for Referral: ________________________________

How did member learn about CBAS program? ________________________________

Name of Referring Person or Agency: ________________________________		Phone: ____________________
Mailing Address/Email: ________________________________		
Name of Primary Care Physician: ____________________	Phone: ____________________	Medical Records Fax: ____________________
Name and Agency of Person Completing Referral Form (if Different Than the Referring Person): ________________________________		Phone: ____________________

Please fax referrals to HPSM at 650-829-2047.

Thank you for your referral!