



CASE MANAGEMENT INTAKE AND REFERRAL FORM

Thank you for requesting the services of this agency. We understand that not all of the information asked for on this form may be available at the time of the referral. Nevertheless, please fill out as completely as possible.

Date: _____

CLIENT INFORMATION

Client's Name _____ Also Known As: _____

Gender: Male Female Date of Birth: _____ Age: _____ Race: _____

Birth Place (if known): _____ Religion: _____ U.S. Citizen: Yes No

Marital Status: Single Married Divorced Widow/Widower Name of Spouse: _____

SSN: _____ - _____ - _____ Primary Language: _____ County of Residence: _____

Current Location: _____

Current/Previous Occupation _____

If facility, admission date: _____ Phone: _____

HOW DID YOU HEAR ABOUT LSF?

Category (check the appropriate one): Nursing Home/ALF Hospital State Agency

Home Health Law Enforcement Court Other

Name of Agency: _____

Contact Person: _____

INFORMATION OF PERSON COMPLETING FORM

Name: _____

Relationship to Client: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Reason why Case Management is needed

MEDICAL

Primary Physician: _____ **Telephone:** _____

Address: _____

Specialist: _____ **Telephone:** _____

Address: _____

Specialist: _____ **Telephone:** _____

Address: _____

Psychiatrist: _____ **Telephone:** _____

Address: _____

Diagnosis: _____

Prognosis: _____

Long Term Plan: _____

Allergies: _____

Medical History: _____

Mental Status / Level of Functioning: _____

LEGAL/ESTATE PLANNING Attach copies (if available)

Client's Attorney: _____ Phone Number: _____

Power of Attorney: Yes No

Name of POA: _____ Contact Number: _____

Address of POA: _____

Is there a Health Care Surrogate: Yes No Unknown

Name of HCS: _____ Contact Number for Surrogate: _____

Address of Surrogate: _____

Does client have a will: Yes No Unknown Location: _____

Is there a trust? Yes No Unknown Location: _____

Name of Trustee: _____ Contact Number: _____

Address of Trustee: _____

Advanced Directives: Yes No Unknown Location: _____

Is there a living will? Yes No Unknown Location:

Are there burial plans? Yes No

With whom and Contact Number: _____

FINANCIAL

Monthly Income: SS \$ _____ SSI \$ _____ SSDI \$ _____ Pension \$ _____

Annuities _____ VA \$ _____ Veterans ID: _____

INSURANCE

Medicare No.: _____ Medicaid No.: _____ Other Insurance: _____

ASSETS / PROPERTY (Including Property, Bank Accounts/Trusts/Automobiles/Life Insurance, etc.)

Real Estate: Yes No Location: _____ Approx. Value: \$ _____

Automobile: Yes No How Titled: _____ Approx. Value: \$ _____

Investments: Type: _____ Approx. Value: \$ _____

Bank Accounts:

Name of Bank: _____ Approx. Value: \$ _____

Address: _____ Telephone: _____

Name of Bank: _____ Approx. Value: \$ _____

Address: _____ Telephone: _____

DEBTS:

Mortgage: \$ _____ Credit Cards: \$ _____ Car Loans: \$ _____

Medical Bills: \$ _____ Other Debt: \$ _____

RESIDENCE

Permanent Address: _____

Anyone Living with Client? Yes No Name: _____

Relationship: _____ Telephone: _____

FAMILY/SIGNIFICANT OTHERS:

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

Name: _____

Address: _____

Relationship: _____ Telephone: _____

COMMUNITY RESOURCES INVOLVED WITH CLIENT:

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

Agency: _____ Contact Person: _____

Address: _____ Telephone: _____

ADDITIONAL COMMENTS: