



# Initial Service Request

**Service(s) Requested (check all that apply)**

- Daily Money Management                       Care Management                       Placement Assistance
- Guardianship                                       Crisis Intervention                       Benefits Applications

Primary Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB/Age: \_\_\_\_\_

Client Address: \_\_\_\_\_

Client Phone #: \_\_\_\_\_

Who shall we contact to arrange the initial assessment? \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Is client at risk?     Yes     No

If yes, has APS been contacted?     Yes     No

Investigator Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Current living situation:**

- Lives alone                                       Client lives in a facility
- Lives with family/friends                       Independent Living
- Professional Caregiver                       Assisted Living
- Homeless     Skilled Nursing
- Other: \_\_\_\_\_

**Benefits/Insurance (check all that apply):**

- Medicare     SSA/SSDI
- HMO     SSI
- Medi-Gap supplement                       Veteran/Vet's Widow
- Long Term Care                                   Civil Servant
- Medicaid     Other: \_\_\_\_\_

**Other Professionals Involved:**

Name	Relationship	Phone # and/or email address

**Next of Kin Information:**

Name	Relationship	Phone # and/or email address

**Assistance Needs (check all that apply):**

- Bathing     Housekeeping
- Dressing     Grocery shopping
- Grooming/Shaving                                   Laundry
- Ambulation/Transfers                               Bill Payment
- Medication Mgmt.                                   Transportation
- Oral hygiene     Meal preparation
- Toilet use     Emergency evacuation

**Client Condition (check all that apply):**

- Memory Impairment                                   Depression
- Poor judgment     Anxiety/Agitation
- Non-compliant     Delusional
- Unsafe housing     Hallucinations
- Blindness     Psychotic behavior
- Hearing Impaired     Drug/alcohol use
- See attached for additional information

**Referring Party Information**

Your Name: \_\_\_\_\_

Your relationship to the client: \_\_\_\_\_

Your daytime phone #: \_\_\_\_\_

Your email address: \_\_\_\_\_

What is the best *time* and *format* (phone or email) to reach you? \_\_\_\_\_

**FAX THIS COMPLETED REFERRAL TO 954-720-2486**