CLAIMANT INFORMATION/REFERRAL

Date:____________
Legal Name of Client:______________________________ Gender:_____
Marital Status: S__ M__ D__ SEP.__ Other:___
Education Level_________
Street Address:____
City, State, Zip:____
Phone Number:__________________________
Social Security Number:________________________
Date of Birth:_______________
Place of Birth:_______________________________
Veteran:_______
Emergency Contact:____ Phone #:___________________
Mother's Name:__________________________ Mother's Maiden Name:__________________________
Mother's Place of Birth:____

RACE/ETHNICITY:

African- American___ Hispanic___
European-American___ Asian/Pacific Islander___
Native-American___ Other:_______________

FAMILY INFORMATION:

Name of Next of Kin:______________________________ Relationship:_______________________
Address:____
Phone #:_____________________ How often do you see them?______________________________
Other Information:____

EMPLOYMENT:

Employer: Phone:__________________ Hours_________
If unemployed, what does client do with his/her time?_______________________________________

DISABILITY TYPE:

Mental Illness___ Type:___________________________
Physical Illness___ Type:________________________
Substance Abuse___ Type:________________________
Developmental ___ Type:_________________________
HIV/Aids___ Other:________________________

INSURANCE INFORMATION:

Medicare__ Tn. Care__ Private Ins.___ Other:_________________________
Current Case Manager:______________________ Phone:_____________________
Agency Represented:____
Primary Care Physician:____________________________
Clinic Address:____
Phone:______________
Psychiatrist:______________________________________
Clinic Address:____
Phone:______________
787 Needed: NO YES
787 Mailed or Faxed to Physician or Psychiatrist NO YES - Date Mailed_____________________

Does Claimant have a court appointed guardian? N Y
Does Claimant have a history of a payee? N Y
Current living situation:
___Alone ____With a relative- (relationship to Claimant)___________________
___With someone else (Whom)______________________ ___ Board & Care Facility:_______________
___Public Institution (Where) ___Private Institution
(Where)________________
Do you expect Claimant's living situation to chane within the next year? Y N
(If Yes, explain what changes are expected and when they will occur)________________________________

OTHER INFORMATION:
Refferred By:____

Why do you need our services?____

What do you expect from us?____

Staff Signature:______________________________________ **Date:**_______________