

RECORD FACE SHEET

Name _____ EMS# _____ DOB ____/____/____			
Address _____		SS# _____	
		Tel.# _____	
Client Rep. Name and Tel. # _____			
ALSA Code: <input type="checkbox"/> NC <input type="checkbox"/> NW <input type="checkbox"/> E <input type="checkbox"/> SC <input type="checkbox"/> SW <input type="checkbox"/> State <input type="checkbox"/> Cong/HUD <input type="checkbox"/> Private <input type="checkbox"/> Demo Project			
1. Referral Rec. ____/____/____ 2. Financial Status Check: ____/____/____ 3. Income _____ Assets _____ 4. Title XIX Pending/Active _____ 5. Coverage Group _____ 6. R.O. Worker Name _____ 7. Phone _____			
Health Screen ____/____/____ Outcome: __D.A. __S.T.P. __Ineligible Refer to Assessment ____/____/____	____/____/____ __D.A. __S.T.P. ____/____/____	____/____/____ __D.A. __S.T.P. ____/____/____	____/____/____ __D.A. __S.T.P. ____/____/____
Initial Assessment Date: ____/____/____	____/____/____	____/____/____	____/____/____
Assessment Outcome: __Refused __Assess Only __CBS			
Category <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3			
SELF DIRECTED CARE start date ____/____/____ stop date ____/____/____ Reason: Provider: _Contact Person: _Tel. # _____ Fax # Other Service Providers Name Contact _Tel. # _____ Fax # _Name _Contact _Tel. # _____ Fax # Billing: Organization _____ EDS	____/____/____ ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____
6 Months Reauthorization Date: ____/____/____ Annual Reassessment Date: ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____	____/____/____ ____/____/____
Discontinuance Date ____/____/____ Reason Code	____/____/____	____/____/____	____/____/____