FACE SHEET

PERSONAL INFORMATION

Name _____ Phone _____ SSN _____

Address _____ Birthdate _____ M/F _____

City _____ State _____ Zip Code _____

Date moved in _____ Date CICL services began _____
Previous address _____
Guardianhip _____ Service Coordinator _____
Medicaid Billing # _____ Medicaid case # _____
Spend-down amount _____ Medicare # _____
Other health insurance (Co. & Policy #) _____
Height _____ Weight _____ Glasses? _____ Dentures? _____
Hair color _____ Distinguishing features _____
Behavioral issues _____
_____

MEDICAL INFORMATION

Hospital preference _____ Religious preference _____
Known allergies _____
_____
Known health problems _____
_____
Over the counter medication restrictions? YES/NO (If yes, refer to medical file.)

DOCTORS

Name _____ _____ _____
Address _____ _____ _____
_____ _____ _____
Phone _____ _____ _____

Name _____ _____ _____
Address _____ _____ _____
_____ _____ _____
Phone _____ _____ _____

Name _____ _____ _____
Address _____ _____ _____
_____ _____ _____
Phone _____ _____ _____

EMPLOYMENT AND INCOME

Income: Work _____ SSI _____ RSDI _____ Food Stamps _____ Other _____
Employed by _____
Address _____ Phone _____
Hire date _____
Vocational contact person _____

SUPERVISION NEEDS

At home _____

In the community _____

Swimming _____

FAMILY/FRIENDS/SIGNIFICANT OTHERS

Name _____ _____ _____
Address _____ _____ _____
_____ _____ _____
Phone _____ _____ _____
Relationship _____ _____ _____

Name _____ _____ _____
Address _____ _____ _____
_____ _____ _____
Phone _____ _____ _____
Relationship _____ _____ _____

NOTES

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Completed by _____ Date _____

This form is to be completed annually or as changes occur.