**Lutheran Services in Iowa**

**Services For People with Disabilities - Hourly**

**Referral/Admission Information**

|  |  |
| --- | --- |
| **Organization** | Lutheran Services in Iowa - PARENT |

**Demographics**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** |  | | | | | | |
| **Middle Name** |  | | | | | | |
| **Last Name** |  | | | | **Suffix** | Jr Sr I II III IV V | |
| **Date of Birth** |  | | | | | | |
| **Gender** | Male  Female | | **Birth Sex** | | | Male  Female Unknown | |
| **Sexual Orientation** | Lesbian/gay/homosexual  Straight/heterosexual  Bisexual Don’t Know  Choose not to disclose Something else: | | | | | | |
| **Gender Identity** | Identifies as:  Male  Female  Chose not to disclose  Male-to-Female (MTF)/Transgender Female/Trans Woman  Female-to-Male (FTM)/Transgender Male/Trans Man  Genderqueer, neither exclusively male nor female  Additional gender category or other, please specify: | | | | | | |
| **Race** |  | | | | | | |
| **Ethnicity** | Asian (not Hispanic or Latino)  Black or African American (not Hispanic or Latino)  Hispanic or Latino  Native American or Alaska Native  Two or more Races (not Hispanic)  White (not Hispanic or Latino)  Not Provided | | | | | | |
| **Marital Status** | Single Married Divorces Separated Partnered Widowed | | | | | | |
| **Religion** |  | | | | | | |
| **Smoking Status** | Current Smoker  Former Smoker  Never Smoked  None | | | | | | |
| **Preferred Language** | English  Spanish  Other: | | | | | | |
| **Other Language** |  | | | **Need Interpreter** | | | Yes  No |
| **Military Status** | Active Guard/Reserves  Full-Time Active  Individual Ready Reserve  National Guard  Reserves None | **Military Service** | | | | | Overseas Reserves |

**Contact Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Contact Name** |  | | | | |
| **Physical Address** |  | | | | |
| **City** |  | | | | |
| **State/Zip** |  | | | **OK to Send Mail?** | Yes No |
| **Mailing Address the same as Physical Address?** | Yes No, list address: | | | | |
| **Client Phone** |  | Cell (ok to call/text reminders)  Cell (ok to call reminder)  Cell (ok to text reminder)  Home (ok to call reminder)  Phone (Do not use for automated messages  Work | | | |
|  | Primary Number? Yes No | | OK to identify as LSI? Yes No | | |
| **Guardian or**  **Representative**  **Phone** |  | Cell (ok to call/text reminders)  Cell (ok to call reminder)  Cell (ok to text reminder)  Home (ok to call reminder)  Phone (Do not use for automated messages  Work | | | |
|  | Primary Number? Yes No | | OK to identify as LSI? Yes No | | |
| **Calling Notes** |  | | | | |
| **E-mail** |  | | | | |

**Employment Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employment Status** | Full Time  Part Time  Student  None | | |
| **Occupation** |  | **Job Title** |  |
| **Not in Labor Force** | Not in Labor Force Disabled Homemaker Retired Student Volunteer  Other: | | |

**Education Information**

|  |  |
| --- | --- |
| **Education** |  |
| **Education Type/Subject** |  |

**Household Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Annual Household Income** |  | | | |
| **Number of Individuals in Household** |  | **Individuals under 18** | |  |
| **Source of Income** | Choose all that apply and select a Primary:  Alimony  Child Support  Family/Relative  Savings/Investment  Wages/Salary Income  FIP  SSDI  SSI | | Primary  Primary  Primary  Primary  Primary  Primary  Primary  Primary | |

**LSI Referral Information**

|  |  |
| --- | --- |
| **Referral Reason** |  |
| **Service Line Referred To** | Services For People with Disabilities |
| **Specific Program Referred To** | Services For People with Disabilities Hourly  Services For People with Disabilities Respite |
| **Placement at Referral** |  |
| **County of Residence** |  |
| **Referral Source** |  |
| **Referral Name** |  |
| **Referral E-mail** |  |
| **Referral Phone** |  |
| **Marketing Type** |  |

**Guarantors/Insurance Holder**

|  |  |
| --- | --- |
| **Self** | Yes  If No, please list: |

**Payer(s)**

|  |  |
| --- | --- |
| **Begin Date** |  |
| **Payer Name** | Waiver  County  Grant  Other: |
| **Plan** | BI CMH Hab HD  ID  Amerigroup (AG) IME Iowa Total Care (ITC) |
| **State ID#** |  |
| **Insurance ID #** |  |

**Program Admission (LSI Office Use)**

|  |  |
| --- | --- |
| **Date/Time** |  |
| **Organization** | Ames  Council Bluffs  Des Moines  Dubuque  Marshalltown  Newton Waterloo |
| **Program** | Services For People with Disabilities Hourly  Services For People with Disabilities Respite |
| **Primary Staff** |  |

**Provider Information– (Respite)**

|  |  |
| --- | --- |
| **Specific Provider Requested?** | Yes  No |
| **Provider Name:** |  |

**Checklist:**

**Current Plan**

**Social History**

**Assessment**