

Face Sheet

(begun at intake, continued at assessment, updated as necessary)

Case # _____

ID # _____

Client name(s)	Sex	Race	DOB	Marital Status	Education Completed	Social Security #

Address

City _____ State _____ Zip _____

Is this address a facility? Yes No Client's phone number(s):
 If yes, level of care:

Directions to client's residence/potential dangers/other notes:

Emergency Contact: _____ Relationship to client: _____

Address _____ Phone number(s): _____

Others in client's household (or significant persons in group settings)

Name	Year of Birth	Relationship to Client	Daytime Phone

Significant others not in client's household

Name	Relationship	Address	Phone(s)

Notes/Comments:

Professional contacts

Name	Profession	Address	Phone

Medicaid # MQB Medicare # A B

Medicaid Worker Phone/ext.

Other IM Case Worker Phone/ext.

Is client/spouse a veteran? Yes No

Private Insurance: Yes No Types(s): Medical Long Term Care Life Burial

Insurance Information:

Advance directives/living will/burial arrangements:

Does the client have a guardian, payee, or a person with a power of attorney? If yes, complete below.

Name	Status	Phone number(s)
Address		

Name	Status	Phone number(s)
Address		

History of services requested/received:

Notes (Counties may wish to identify additional information to be recorded here.)