

Initial Contact Sheet – Adult Services

(Inquiries/Referrals)

Date: _____

Contact Name: _____ Contact Phone #: _____

Email: _____

Name of Client Requesting Service: _____

Age: _____

General Information:

MESSAGE RECEIVED BY: _____

Binder(s):	Adult Services					Page:	1 of 2
Section(s):	Entry/Exit	R	01-11-08	R/R	Sept 24/12	R/R	Apr 4/18
Program Area(s):	Adult Disability						

1. CURRENT SITUATION/ SUPPORT SYSTEM (funding source, guardianship, etc.)

2. POTENTIAL SUPPORTS REQUIRED (e.g. medical, residential, physical, in-home, etc.)

3. SPECIAL CONSIDERATIONS? (Risk Assessments, transportation, etc.)

4. FOLLOW-UP REQUIRED/TIMELINES:

Coordinator: _____ **Date:** _____

Binder(s):	Adult Services					Page:	2 of 2
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