Lex-Care-Inc. "Make A Difference" REFERRAL FORM

***Received*____________*Sent*____________**
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Fax referral to 859.422.5993

Referred by:

Name: ____ Email: ____________________________

Agency: ____ Are you a Lex-Care member? ____ Yes ____ No

Phone: ______________________ Cell / Other :______________________ FAX: ______________________

Address:____ City: ____________________ Zip: __________

Applicant Information:

Name: ____ SS#:____________________________

DOB: ______________ Gender: _________ Race: _________ Marital Status: ________ Phone: ________________

Address: ____________________________________ City: ______________________ Zip: ______________

Other Household Members (list names, ages, SS# of adults) ____

____

Alternate Contact Name: ____ Phone: ____________________

Total Household Income and Source(s): ____

Food Stamps: ________ No ________ Yes Amount: $_____________

Monthly Expenses (list each separately): ____

____ Total : ______________

If outgoing expenses are more than monthly income, explain how applicant plans to make up the difference: ____________________

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____

Amount of assistance requested: $ _________________________ Type of bill: _________________________

Describe situation and reason for need for assistance by answering the following (use separate sheet if necessary):

1. Why is applicant in need of assistance / what has put them in this situation? (If situation is due to medical condition, please provide diagnosis and prognosis):

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2. What is the applicants work history / job skill? (Currently working? on leave? occupation? employer holding job? return to work date?)

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3. If the bill is more than $750, please explain how the client plans to pay the balance of the bill. Please note that Lex-Care cannot release funds to the vendor until the client has secured the funds for the balance of the bill.

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4. How will your client meet expenses next month?

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5. What are the LONG RANGE PLANS for your client?

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6 .The Lex-Care Financial Assistance Fund is to be used as a last resource. What other resources have been utilized or attempted to be accessed?

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8. Any other pertinent information: (cut off date, eviction date, etc)

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Payment made to the following:

Vendor: ____

Contact Person: __________________________________

Address: _______________________________________

City/State/Zip: __________________________________

Phone: ____

Account #: ______________________________________

Vendor: ____

Contact Person: __________________________________

Address: _______________________________________

City/State/Zip: __________________________________

Phone: ____

Account #: ______________________________________

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I have verified client's needs and submitted all necessary documentation with this intake form. I agree to accept responsibility of case follow-up should Lex-Care need assistance with this request. I also understand that my name and agency name will appear in the column.

____

Referral Source / Social Worker   Date

ALL INFORMATION MUST BE COMPLETED OR APPLICATION WILL NOT BE ACCEPTED.

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If you have any questions feel free to contact us at 859.699.5993 or at gethelp@lexcare.org