Alice's Place SFC Screening From (*required)

*Language: English___ Spanish___ Vietnamese___ Chinese___ Other (specify)_____

*Name_____ DOB___/___/_____ Sex_____

Medicaid_____Yes _____No SSN: _____/_____/_____ Medicaid Number_____

Medicare Number_____

SSI_____Yes _____No_____ Amount of total monthly income $_____

*Address_____ Phone_____

Housing: Alone_____ With relative/friend_____ Hospital_____ Personal Care Home_____Nursing Home_____ Other_____

Physician: _____ Date of Last Visit_____

Address_____

Telephone Number_____

Fax Number_____

What has the applicant been diagnosed with:

_____

_____

Do the family member walk with a device: (Please Circle) Wheelchair Walker Cane Rollator

Primary Caregiver relationship: _____Phone_____

Address_____

STOP

Referred for _____ Assessment on: _____

Referred for _____Services

Other_____

Initial Screener_____ Screening Date_____

Please Fax to 478-254-9736

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