



LEGACY HOUSE

Inquiry Form

Today's Date: _____

Assisted Living Adult Day Health Adult Day Care

Applicant Name:	Contact Name:
Applicant Phone #:	Contact Phone #:
Applicant Address:	Contact Address:
Primary Language:	Relation to Applicant:

Date of Birth/Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status:
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, PIC Number: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Number: _____ SSN: _____	
Present living situation:	<input type="checkbox"/> Living alone	<input type="checkbox"/> Living with _____
<input type="checkbox"/> House	<input type="checkbox"/> Apartment	<input type="checkbox"/> Retirement Home
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Other:	

Who is your primary physician? Name: _____ Phone: _____ Fax: _____	
Who is your DSHS SSW? Name: _____ Phone: _____ Fax: _____	
Why do you need our services at this time?	
What are your health concerns?	
How did you hear about Legacy House?	<input type="checkbox"/> Friend <input type="checkbox"/> ACRS <input type="checkbox"/> Advertisement <input type="checkbox"/> Medical Professional
	<input type="checkbox"/> Family <input type="checkbox"/> CISC <input type="checkbox"/> Phone Book <input type="checkbox"/> Other:



LEGACY HOUSE
INTERNATIONAL DISTRICT
VILLAGE SQUARE

**RELEASE OF PROTECTED HEALTH INFORMATION
TO LEGACY HOUSE**

I, _____, authorize the release of health, psychosocial and financial information from the State/Community Case Manager for review by staff at Legacy House for evaluation prior to move in/admission to Legacy House or Legacy House Programs.

Signature of client/resident

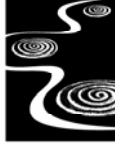
Date

or

Signature of client/resident legally responsible arty

Date

**Legacy House
803 South Lane Street
Seattle, WA 98104
(206) 292-5184 ph
(206) 292-5271 fax**



LEGACY HOUSE
INTERNATIONAL DISTRICT
VILLAGE SQUARE

**RELEASE OF PROTECTED HEALTH INFORMATION
TO LEGACY HOUSE**

I, _____, authorize the release of medical information from my Health Care Provider for review by staff at Legacy House for evaluation prior to move-in/admission to Legacy House or LH programs.

Signature of client/resident

Date

or

Signature of client/resident legally responsible party

Date

**Legacy House
803 South Lane Street
Seattle, WA 98104
(206) 292-5184 ph
(206) 292-5271 fax**