**North Carolina Department of Health and Human Services**

**Division of Aging and Adult Services**

**Face Sheet**

 Case #

(Complete at initial contact and update as needed) SIS ID #

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Name(s)** | **Sex** | **Race** | **DOB** | **Marital Status** | **Education Completed** | **Social Security #** |
|       |       |       | Click or tap to enter a date. |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Address** | **City** | **State** | **Zip** |
|       |       |       |       |

Is this address a facility [ ]  Yes [ ]  No

If yes, name of facility and level of care:

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name(s)** | **Home Phone** | **Cell/Mobile Phone** | **Email Address (if applicable)** |
|       |       |       |       |
|       |       |       |       |

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

|  |
| --- |
| **Emergency Contact** |
| Name | Relationship to client |
|       |       |
| Address: | Phone number(s): |
|       |       |

**Others in client’s household (or significant person in group settings)**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Year of birth | Relationship to client | Daytime phone |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Significant others not in client’s household**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Year of birth | Relationship to client | Daytime phone |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| Notes/Comments:      |

**Professional Contacts**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Profession | Address | Phone |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|  |  |  |  |
| Client Diagnoses: | Client Allergies: |
|       |       |

|  |  |  |
| --- | --- | --- |
| 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

Insurance type(s) [ ]  Medical [ ]  Long term care [ ]  Life [ ]  Burial

Insurance information:

Advance directives: [ ]  Yes [ ]  No MOST Form [ ]  Yes [ ]  No

Living will: [ ]  Yes [ ]  No Health care POA [ ]  Yes [ ]  No

Burial arrangements ( List below):

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

|  |  |  |
| --- | --- | --- |
| Name | Status | Phone number(s) |
|       |       |       |
|       |       |       |

History of services requested/received:

Notes: