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: ☐ Female ☐ Male	Marital Status:
Medicaid: ☐ Yes ☐ No	If yes, PIC Number:	
Medicare: ☐ Yes ☐ No	If yes, Number: _____ SSN: _____	

Present living situation: ☐ Living alone ☐ Living with _____

☐ House ☐ Apartment ☐ Retirement Home
☐ Assisted Living ☐ Hospital ☐ Nursing Home
☐ Adult Family Home ☐ 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? ☐ Friend ☐ ACRS ☐ Advertisement ☐ Medical Professional ☐ Family ☐ CISC ☐ Phone Book ☐ 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

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 <u>prior</u> to move-in/admission to Legacy House or LH programs.

_____ _____
Signature of client/resident **Date**

or

_____ _____
Signature of client/resident legally responsible party **Date**

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