

Sholom Community Alliance

Services Questionnaire

Applicant Name: _____ Date: _____

Current Address: _____ Phone: _____

_____ Cell/Work: _____

Contact Person: _____ Phone: _____

_____ Cell/Work: _____

Applicant SS#: _____/_____/_____ Applicant DOB: _____/_____/_____

Anticipated Move In Date: _____

Would you like an Assessment by a Sholom Home Health Care representative? No ___ Yes ___

Are you currently receiving Home Care services? No ___ Yes ___ Provider _____

Do you receive Medical Assistance? No ___ Yes ___ MA Number: _____

Are you on an Elderly Waiver Program? No ___ Yes ___ Case Manager: _____

Phone Number: _____

If you are not on Elderly Waiver and would like information please call: 612-348-4500.

Are you currently in a nursing home? No ___ Yes ___ If so, which one? _____

Do you belong to an MSHO? No ___ Yes ___ Which one? _____

Care Coordinator: _____ Phone Number: _____

What types of services are you looking for: _____

Form completed/received by: _____

Copy to: Housing Manager _____; Social Services _____; Home Care _____; Assessment scheduled _____