COMMUNITY SERVICES
Keen Center for Senior Resources

Print Form

PARTICIPANT CONTACT FORM

FOR OFFICE USE ONLY

☐ KCSR ☐ CARE MANAGEMENT ☐ OTHER _____

☐ MOW ☐ NON-RESIDENT STAFF ASSIGNED _____

DATE ASSIGNED _____

DATE MOVED TO CM _____

DATE KCSR CLOSED _____

PARTICIPANT INFORMATION

SENIOR'S NAME* ☐ MALE ☐ FEMALE	PHONE*	DATE OF BIRTH/AGE	
ADDRESS*	CITY	STATE	ZIP
E-MAIL*	CULTURE/LANGUAGE	HEALTH INSURANCE	
CALLER'S NAME*	PHONE*	RELATIONSHIP TO PARTICIPANT ☐ SELF ☐ AGENCY ☐ FAMILY ☐ OTHER: _____	
ADDRESS*	CITY	STATE	ZIP

REASON FOR CONTACT

☐ CAREGIVING ☐ EMOTIONAL HEALTH ☐ FINANCIAL ☐ HEALTH ☐ HOUSING
☐ HEALTH INSURANCE ☐ LEGAL ☐ LANGUAGE/CULTURAL ☐ NUTRITION ☐ SAFETY
☐ SOCIALIZATION ☐ TRANSPORTATION ☐ OTHER _____

COMMENTS:

LIST SPECIFIC REFERRALS/RESOURCES PROVIDED

☐ ADHC ☐ ASSISTANCE PROGRAM(S) ☐ APS ☐ CARE MANAGEMENT ☐ EMPLOYMENT
☐ ERS ☐ FRIENDLY VISITOR ☐ FINANCIAL ☐ HANDYMAN ☐ HEALTH
☐ HOUSING ☐ IN-HOME HELP ☐ INSURANCE ☐ LEGAL ☐ MEDICAL EQUIPMENT
☐ MENTAL HEALTH ☐ MOW ☐ SS/SSI ☐ SUPPORT GROUP ☐ TRANSPORTATION
☐ VETERANS ☐ OTHER _____

COMMENTS:

FOR OFFICE USE ONLY HOW DID CALLER HEAR ABOUT US? _____ (AGENCY, FRIEND, ETC.)

REQUEST RECEIVED BY: ☐ E-MAIL ☐ PHONE ☐ WALK-IN DATE: _____

REVIEWED BY: _____ STAFF/VOLUNTEER NAME: _____