Lutheran Social Service of Minnesota

Referral Form

Health Care Agent / Power of Attorney / Personal Representative of Estate

Date: _____ Person making referral: _____

Phone: _____ Agency/position: _____

Referral for: ☐ **Health Care Agent** ☐ **Personal Representative of Estate** ☐ **Power of Attorney**

* *In the following sections, if you need more room to record your responses, please attach an additional sheet.*

Client Data:

Full Name: _____ Phone: _____

Address: _____ City: _____

State, Zip: _____ County: _____

Marital Status: _____ Gender: _____

Employment Status: _____ Language(s) Spoken: _____

Social Security Number: _____ Medicare Number: _____

Medical Assistance Number: _____ Other Insurance: _____

County Social Worker: _____ Phone : _____

Financial Worker: _____ Phone : _____

Physician: _____ Phone : _____

Clinic: _____ Clinic Address: _____

Clinic City: _____ Clinic State, Zip: _____

Preferred Hospital: _____

Emergency Contact Name: _____ Emergency Contact's Relationship: _____

Emergency Contact's Phone: _____ Emergency Contact's Address: _____

Emergency Contact City: _____ Emergency Contact State, Zip: _____

Current Placement (if not at a home):

Facility: _____ Address: _____

Administrator: _____ City: _____

Social Worker: _____ State, Zip: _____

Admission Date: _____ Phone: _____ Fax: _____

Reason for Admission:

_____

_____

_____

_____

_____

Monthly Income (sources & amounts):

Social Security:

Pension (*specify*):

Veteran's Benefits:

Other (*specify*):

Veteran Status / Services Received:

Assets (location & amounts):

Real Estate:

Personal Property:

Status of House/Apartment:

Status of Personal Property:

Bank Accounts:

Insurance (*home, auto, etc.*):

Debts:

Funeral (*prepaid amount, burial items*):

Interested Persons:

Spouse: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Partner/Caregiver: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Child: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Child: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Child: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Parent: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Parent: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Health Care Agent: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Legal Representative: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Pastor: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Other: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Other Contacts:

Accountant: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Attorney: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Attorney-In-Fact: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Home Health Care: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Trust Officer/Bank: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Other: _____ Address: _____
Phone: _____ City: _____
State, Zip: _____

Social History (*optional*):

Religion/Church:

Ethnic Background:

Education:

Trade/Profession:

Military Experience:

Funeral Home Preference:

Current Situation/Reason for Referral:

_____
_____
_____
_____
_____

Billing Information:

Party responsible for payment to LSS: _____

Relationship: _____ Address: _____

Phone: _____ City: _____

State, Zip: _____

Funeral / Burial Plans:

Prepaid Funeral Plan: _____ Policy Number: _____

Name: _____ Address: _____

Phone: _____ City: _____

State, Zip: _____

Burial Plan — Cremation (*if yes, complete cremation authorization*):

_____
_____
_____
_____
_____

Deceased Notices:

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____

Interested Persons Notices:

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____

Name: _____ Address: _____

Phone: _____ City: _____

Relationship: _____ State, Zip: _____