

Referral Intake Form

Mail to: LifeStream Services, Inc. PO Box 308 Yorktown, IN 47396 or fax to: 765-759-0060 Attention: Information and Referral
or attach and sendto:211@lifestreaminc.org

Referral Source

Agency or Company Name:	
Name of Person Completing Referral:	
Phone Number:	Fax Number:

Client Information

(last)	(first)	(middle initial)
Name:		
(number and street)	(City)	(State) (zip code)
Address:		
Home Phone:		Date of Birth:
(check one) Gender: <input type="checkbox"/> Male or <input type="checkbox"/> Female	Social Security Number:	Medicaid Number (if applicable):
(check one) Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Spouse of	Marital Status <input type="checkbox"/> Wid <input type="checkbox"/> Married <input type="checkbox"/> Div <input type="checkbox"/> Single <input type="checkbox"/> Sep <input type="checkbox"/> UnK	Number in Household:

Caregiver Information

(last)	(first)	(middle initial)
Name:		
(number and street)	(City)	(State) (zip code)
Address:		
Home Phone:	Work Phone:	Other:
If this is a Caregiver Referral, please provide the following:		
Date of Birth:	Relationship:	

Contact Person (family/friend)

(last)	(first)	(middle initial)
Name:		
(number and street)	(City)	(State) (zip code)
Address:		
Home Phone:	Work Phone:	Other:
		Relationship:

Diagnosis/Condition

Requested Services

Please Note

**Completion of the Referral Intake Form does not imply or guarantee the client will be eligible for any funded services.
All services are available to anyone wishing to privately pay for them.**