SCREENING AND REFERRAL FORM

Delaware Medical—Legal Partnership Project

REFERRAL INFORMATION	CLIENT INFORMATION
Healthcare Staff Name:	Name:
Preferred Staff Contact: (Phone / Pager / Email)	Phone / email:
Healthcare Provider / Location:	Address:
Today's Date:	Okay to leave a message? Yes No
Agency / entity / person the problem is with:	Preferred language:
	Pregnant? Yes; # of weeks: ____________ No

PRESENTING PROBLEM(S) (check all that apply):

The Project does not handle defense of criminal matters, malpractice, or traffic offenses.

I—Income Supports

Do you need help getting or keeping any of the following benefits or services for your family: WIC, SSI/SSDI, Cash Assistance (TANF / General Assistance / Refugee Assistance), purchase of care / day care subsidy? __yes __no __N/A

Do you and your family not have enough food, or have problems with SNAP /Food Stamps? __yes __no __N/A

Do you or your children lack health insurance or have problems with healthcare coverage (Medicaid, Medical Assistance, Medicare, Prescription Assistance)? __yes __no __N/A

Other income maintenance problem? __yes __no __N/A

H - Housing & Utilities

Do you have adequate housing for your family?
__yes __no __N/A

Any problematic condition in your house/apartment (rodents, insects, mold, etc.)? __yes __no __N/A

Are you at risk of or losing your housing (evictions, lock-outs, late rent, warnings, lease violations)? __yes __no __N/A

Are you having problems with subsidized (Section 8, tax credit, etc.) or public housing? __yes __no __N/A

Have you gotten behind on any utility bills, or received a shut-off notice? __yes __no __N/A

Do you feel you have been discriminated against in connection to housing? __yes __no __N/A

Other housing problem? __yes __no __N/A

E– Education & Employment

Are you being discriminated against at work, including because of pregnancy? __yes __no __N/A

Do you have a disability and are you experiencing problems getting services from the state to help you work?
__yes __no __N/A

Do you or your children need disability related accommodations at school or higher education? __yes __no __N/A

Do you have a child with a mental/physical disability, problems learning or behaving at school? __yes __no __N/A

L—Legal Immigration Status

Do you have any concerns about your immigration status?
__yes __no __N/A

Have you been discouraged from applying for public benefits for you or your children because of immigration status?
__yes __no __N/A

Are you concerned about your family's health and stability for any immigration related reason? __yes __no __N/A

P—Personal & Family Stability

Is Division of Family Services involved with you at all? Do you have children not in your care who you want more contact with?
__yes __no __N/A

Do you have concerns about your safety or the safety of your family? (detail on reverse) ? __yes __no __N/A

Do you have a disability related barrier to government programs, including transportation, or other public places or services ? __yes __no __N/A

Any other disability or special healthcare needs for you or your children, including Advanced Healthcare Directive, Power of Attorney, voting access and disability rights? If so, can you be more specific (detail on reverse) ? __yes __no __N/A

Other problems / concerns that a lawyer might be able to help with, or that causes severe anxiety or stress (explain on reverse) ? __yes __no __N/A

SUMMARY OF PROBLEM OR CONCERN

____

____

____

____

____

Check here if you think there may be a court or hearing date within 10 days: Date (if known): __________

CLIENT AUTHORIZATION; AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

I, ____________________________________ (patient name), authorize the health care provider named below to talk with Community Legal Aid Society, Inc. (CLASI) about my possible legal problem to see if CLASI can help resolve the problem or refer me to other resources. **I also authorize CLASI to discuss my possible legal problem with my health care provider to help resolve my problem.**

I hereby authorize the following health care provider: _______________________________________

RECIPIENT INFORMATION

To disclose the following protected health information to:
Community Legal Aid Society Inc. (CLASI) Street Address: 100 West 10th Street, Suite 801
City: Wilmington State: DE Zip Code: 19801

Please indicate the information or types of information to be disclosed: Information necessary to make a referral for possible legal assistance, including name, date of birth, contact information, pregnancy status, information related to a health or disability diagnosis if related to the legal problem, and information about the legal problem.
Specify dates (or date ranges) if applicable: ALL DATES
This request is for the purpose of: referral for possible legal assistance

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire in six months or on the following date:_______________

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED PLEASE INITIAL HERE:_______

I have carefully read and understand the above and do herein expressly and voluntarily authorize disclosure of information between the healthcare provider listed above and CLASI.

_____________________________________	_____________	__________________________
Signature of Patient / Representative	Date	Representative's relationship / Representative's authority

Please fax or email this form to: Jane Curschmann, Community Legal Aid Society, Inc.
FAX: (302) 575-0840 PHONE: (302) 575-0660, ext. 211
jcurschmann@declasi.org