CLIENT REQUEST FOR SERVICE FORM

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Date: 9/11/2024

Caller requesting information on or making a referral for one or more of the following services:

☑ Home Delivered Meal

☐ Homemaking (housekeeping)

☐ Group Dining ☐ Transportation to Senior Center

☐ Medical Transportation (Non-Medicaid)

☐ Evidence-based/Health Promotions

☐ Family Caregiver / Seniors Raising Children Program / Alzheimer's/ Dementia Respite

☐ Other (Ombudsman, Legal Services, Medicare, Medicaid, SC Thrive/CLTC applications, etc.):

Potential Client's Name	Potential Client's Physical Address:	Mailing Address (if different)

Date of Birth:	Age:	Client's Phone # (Include special code if needed):

Emergency Contact (name & number):	Secondary Emergency Contact (name & number):

Referred by: ☐ Self ☑ Other Name:	Relationship:	Referral's Phone #:

List any important information provided by the caller concerning the client *(examples: emergency service needed, types of disability, client is homebound, client is not able to drive, etc.)*

Name of Individual Taking Call:	SC ACT Client ID#
Mattie Davis	

Revised 7/2021