

**CLIENT TRANSFER: ASSISTED LIVING FACILITY CLIENT FACE SHEET**

- See DQA publication [P-02067, Assisted Living Facility and Hospital Interface](#).
- A copy of the client's face sheet would be included in the blue envelope packet.

**GENERAL**

|                           |            |      |             |       |                   |
|---------------------------|------------|------|-------------|-------|-------------------|
| Name – Client             |            |      |             | Phone |                   |
| Address                   |            | City | County      |       | State<br>Zip Code |
| DOA:                      | DOB / Age: |      | Height:     |       |                   |
| Medicaid No:              | SSN:       |      | Weight:     |       |                   |
| Medicare No:              | Sex:       |      | Hair Color: |       |                   |
| Effective Date:           | Race:      |      | Eye Color:  |       |                   |
| Medicare Part D Provider: |            |      |             | No.   |                   |

**DIAGNOSIS**

|   |  |   |
|---|--|---|
|   | Axis I:  |   |
|   | Axis II:   |   |
|   | Axis III:  |   |
|   | Allergies:   |   |
| Behavior plan needed? <input type="checkbox"/> Y <input type="checkbox"/> N | Consent for psych meds needed? <input type="checkbox"/> Y <input type="checkbox"/> N | Health log updated? <input type="checkbox"/> Y <input type="checkbox"/> N |

**GUARDIAN / CASE MANAGERS**

|  |                                  |
|--|----------------------------------|
| Name – Guardian                        | Phone – Guardian                 |
| Name – Family Care Case Manager        | Phone – Family Care Case Manager |
| Name – Managed Care Organization (MCO) | Phone – MCO                      |

**CONTACT INFORMATION**

| Contacts                | Name | Address | Phone |
|-------------------------|------|---------|-------|
| Emergency Contact       |      |         |       |
| Primary Care Physician  |      |         |       |
| Hospital                |      |         |       |
| Pharmacist              |      |         |       |
| Dentist                 |      |         |       |
| Eye                     |      |         |       |
| Psychiatrist            |      |         |       |
| Podiatrist              |      |         |       |
| Vocational Provider     |      |         |       |
| Transportation Provider |      |         |       |