Lesly Starling RN, ReSource Nurse
Sandra Doll, Community Health Worker

Name: _____ Date of Birth: _____

SS#: _____ Phone: _____

Emergency Contact #1: _____

Emergency Contact #2: _____

May we contact your emergency contact if we are unable to reach you by phone? _____

What level of education do you have ? _____

Do you have Medicare? Yes _____ No _____ Coverage: _____ A _____ B _____ C _____ D _____

Do you have Medicaid? Yes _____ No _____ Coverage: _____ Waiver? _____

Are you a Veteran? Yes _____ No _____ Dates of Service: _____

Do you have Veteran's Benefits? Yes _____ No _____ Are you the spouse of a Veteran? Yes _____ No _____

Please share general information about your current medical challenges: _____

_____

Monthly Income	**Amount**	**Expenses**	**Amount**	**Support System**	
Wages, Tips		Rent/Mortgage		Family	
Social Security		Electricity		Friends	
SSDI/SSI		Gas		Church	
VA		Water		Neighbors	
Pension/Retirement		Garbage		Groceries	
SNAP		Groceries		Meals	
Worker's Comp		Medical Premiums		Transportation	
Other		Prescriptions		House Cleaner	
Other		Auto Expenses		Errands	
Resources	**Value**	Fuel		$ Management	
Vehicles		Clothing		Caregiver	
Home		Telephone		Socialization	
Property		Cable		Peer	
Stocks/Bonds/IRA		Internet		Support Group	
Rec Vehicles		Credit Cards		Hobby	
Other		Other		Pet	

Physical Limitations (please check all that apply): Oxygen _____ Wheelchair _____ Walker _____ Crutches _____ Glasses _____

Hearing Aides _____ Handicap Accessibility _____ Prosthesis _____ Pump _____ Wounds _____ Other _____

Technology (please check all that apply): Android ____ iPhone ____Flip Phone ____Computer ____Tablet ____Internet ____

ReSource Agreement

Please sign below to indicate that you are willing to have the ReSource Team help connect you with community resources necessary to aid in your health and well-being. Your signature gives the ReSource Team authorization to talk with your financial or medical team, if necessary, to discuss your history, physical report and medication record to help create a comprehensive network of care and to connect you to appropriate resources. You have the right to revoke this authorization in writing at any time by contacting the ReSource Nurse at 406-758-1394.

Signature of ReSource Team Client: _____ Date:_____

Printed Name:_____

If legal representative, what is your relationship to the patient: _____

Made possible with support from the Robert Wood Johnson Foundation