

## Community Living Program

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Consumer Name:

Consumer Address:

DATE:

Site: 1b 1c 3a 3b 3c 4 6 8 11 14 Consumer Phone:

Needs assistance with : Transferring Bed Mobility  
Dressing Bathing Wheeling/Mobility

Proxy Name:

Memory issues Yes No

Proxy Phone:

Difficulty Making Decisions? Yes No

Diagnosis of Dementia? Yes No

Proxy Relationship:

Immediate Need? (Circle all that apply)

Caregiver loss or burnout Crisis

Assets >\$2000 Yes No

Hospital Discharge APS

Assets >\$25,000 Yes No

NH Discharge Other

Given the current situation, are you considering  
nursing facility placement? Yes No

Monthly Income \_\_\_\_\_

Veteran? Yes No

IMMINENT RISK REFERRAL	YES	NO
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IMMINENT RISK REFERRAL	YES	NO
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**Community Living Program**

Primary Business Address

Your Address Line 2

Your Address Line 3

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this publication to multiple recipients.

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