DSS-4449B (rev.4/97)

❒ AH ❒ EHP ❒ ALP
IDENTIFYING DATA

NAME OF FACILITY: ____

Name ______________________________

❒ ALP MA Start date of Care ____________________

Home address (prior to admission):

Street ______________________________

City _____________ **State** ____ **Zip** ________

Admitted From (if different from above)

____

Street ______________________________

City _____________ **State** ____ **Zip** _______

Language(s) Spoken/Understands ___________

____

Religion ______________________________

Marital Status ❒ Married ❒ Separated ❒ Single

❒ Divorced ❒ Widowed ❒ Unknown

Burial Instructions ________________________

____

Other Health/Mental Health Providers:

Name ______________________________

Address: ______________________________

Phone # ______________________________

Hospital of Choice ________________________

Primary Physician ________________________

Date of Birth ____________ **Sex: ❒ Male ❒ Female**

Social Security # ______________________________

Medicaid CIN # ______________________________

Medicare # __________________ **❒ Part A ❒ Part B**

Other Health Insurance Co. ______________________

Policy Number ______________________________

Source of Income/Benefits;(Check ALL that apply)

❒ SSI ❒ Public Assistance ❒ Pension ❒ Social Ser.

❒ Veteran's ❒ Other __________________________

Next of Kin/Guardian____________________________

Street ______________________________

City ___________________ **State** _____ **Zip** ________

Relationship _____________ **Phone #** ______________

Notify in Case of Emergency (if different from above)

Name: ______________________________

Address ______________________________

City _________________ **State** _____ **Zip** __________

Phone # ______________________________

Address ______________________________

Phone # ______________________________

Street: ______________________________ **City** __________________ **State** _____ **Zip** ___________

Admission Date ______________________________

Discharged Date ______________________ **Reason:** ______________________________

Discharge to Address ____