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**Referral Date:** Click here to enter a date.

REFERRING AGENCY:

|  |  |
| --- | --- |
| Agency: | FamilyCare Care Coordinator/Case Manager (Name): |
| FamilyCare  8l25 NE Multnomah, Suite 1400  Portland, OR 97232 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Your phone:  (include ext.) | Alternate Phone: | Email: | Fax: |
|  |  |  |  |

MEMBER INFORMATION:

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name: | First Name: | Date of Birth (mm/dd/yyyy): | FamilyCare Member #  (10 digits): |
|  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Street Address: | | | | | Apt. or Suite number: | | |
|  | | | | |  | | |
| City: | | State: | | Zip Code: | | County: | |
|  | | OR | |  | |  | |
| Home/Primary Phone: | Cell/Alternate Phone: | | Emergency Contact (name, relationship): | | | | Emergency Contact Phone: |
|  |  | |  | | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Age: |  | Veteran Status: | Choose from dropdown: |
| Gender: | Choose from dropdown: | English Fluency: | Choose from dropdown: |
| Transgender: | Choose from dropdown: | Primary Language  *(if not English):* |  |
| Race: | Choose from dropdown: | Functionally Impaired: | Choose from dropdown: |
| Ethnicity: | Choose from dropdown: | *(If multiple impairments, list here):* |  |
|  | | |
| GCID# *(Admin use only):* |  | Call ID# *(Admin use only):* |  |

MEAL DELIVERY INFORMATION:

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**Desired Start Date for Meals:** Click here to enter a date:

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**Desired End Date for Meals:** Click here to enter a date:

**Meal Schedule:**

Total number of weekday meals: Choose 1-10:

(example: one daily meal=5 Total; two daily meals=10 Total)

Number of weekend meals: Choose 1-4:

Comments:

|  |
| --- |
|  |

DIET INFORMATION (check all that apply):

**Regular:** (Choose yes or no:

**Diabetic:** (Choose yes or no:

**Next/Final Step:**

* **Email this form (with read-receipt) to:** [adrc@multco.us](mailto:adrc@multco.us)
* **Questions?** Call Kurt: 503-988-8175, kurt.perkins@multco.us