Case Management (Current Client)

Jewish Family SERVICES

Client Name: _____ **Client DOB:** ____/_____/____

Client Address: _____

City: _____ **County** _____ **Zip**_____

Preferred Phone _____ *check if JFS is authorized to leave message?* ❒

Other Phone _____ *check if JFS is authorized to leave message?* ❒

Email _____ *check if JFS is authorized to send information?* ❒

Gender: *M* *F* **Race:** _____ **Religion:**_____

Marital Status: *Single* *Married* *Divorced* *Separated* *Widowed* *Other* _____

 # Adults Living in Home: _____ **# Children Living in Home:** _____

Employment Status: *Full-Time* *Part-Time* *Temporary* *Unemployed* *Retired* *Student* *Other*

How did you hear about JFS : ☐Clergy, ☐Friend / Family , ☐JFS Marketing, ☐Jewish Agency, ☐Non-Jewish Agency, ☐Physician, ☐Self, Synagogue, ☐Volunteer, ☐Website, ☐Psychology Today , ☐Other _____

Reason for Contacting JFS: _____

Please initial each line:

_____ I have read and agree to the Office Policies, Client Rights and Privacy Practices(you may view a copy of these on the JFS website or request a copy from the JFS office).

_____ I understand that I must complete the following forms prior to consultation, and update them annually:

1. Emergency Information
2. Policies and Guidelines
3. Case Management Application

_____ I grant permission for JFS, and their representatives, to communicate with me via email as indicated below. I confirm that the email address that I have given is a private email and I release JFS from any responsibility for access to my private email by any person not authorized by me. See JFS Email Informed Consent Policy.

I authorize my therapist/case worker to communicate with me via e-mail. Yes❒ No❒

I authorize JFS staff to send appointment reminders via e-mail. Yes❒ No❒

I would like to receive e-mail communication regarding JFS services and programs. Yes❒ No❒

CLIENT CONSENT FOR SERVICES

Please initial each line:

_____ We/I agree to allow Jewish Family Services of Greater Charlotte (JFS) to provide services to me/my ward.

_____ We/I will participate in developing a service plan, which will identify goals to work toward, time frames and methods to achieve these goals.

By signing below, I certify that I have answered the questions above honestly and accurately.

_____ Date_____/_____/_____

Signature of JFS Client or Guardian

_____ Date_____/_____/_____

Printed Name of JFS Client or Guardian

_____ Date_____/_____/_____

Signature of JFS Staff Member

Updated 1-1-2020

Case Management (Current Client)

Jewish Family SERVICES

EMERGENCY INFORMATION

Client Name: _____ **Client DOB:** ____/_____/____

Primary Care Physician: _____**Phone:** _____

Please list Your Preferred Hospital/Clinic: _____ **City:**_____

Do you have insurance? Yes_____ No _____

Primary Insurance Carrier _____**Name of Policy Holder:**_____

Policy #: _____ **Group #:** _____ **DOB of Policy Holder:** ____/_____/_____

Secondary Insurance Carrier _____**Name of Policy Holder:**_____

Policy #: _____ **Group #:** _____ **DOB of Policy Holder:** ____/_____/_____

In Case of Emergency, Please Contact the Following Individual:

Name: _____ **Relationship:** _____

Preferred Phone Number: _____

I hereby give permission for JFS to provide, seek, and consent to emergency treatment for the client named above, as may be necessary.

_____ Date _____/_____/_____

Signature of JFS Client or Guardian

_____ Date _____/_____/_____

Printed Name of JFS Client or Guardian

Case Management (Current Client)

Jewish Family SERVICES

Client Name: _____ **Client DOB:** _____ **Client History #** _____

Affiliation with Jewish Agency (LJCC, Temple, Preschool, etc.): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (H)_____ (W)_____ (C)_____

E Mail:_____ Preferred Method of Contact:_____

Request for: Food Pantry ❒ Tzedakah ❒ Reduced Fee ❒

Provide Information on All People Who Live in the Household (including children. Provide copies of paycheck stubs for the last 60 days and last year's Tax Return and W-2 for each working person listed below.

Name	DOB	Relationship	Social Security Number	Occupation	Monthly Income including Tips & Bonuses, Before Taxes, Deductions (Gross Income)	How Often Paid (monthly, weekly, etc.)
		SELF			$	
					$	
					$	
					$	
					$	
Total Monthly Income above for all people living in the household $_____						

List All Custodial Parents/Legal Guardians Who Resides Outside The Household:

Name	DOB	Relationship

Do you currently or have you previously received any financial assistance from other Jewish Agencies?

Name of Institution (e.g., JCC, CJP, JPS, CJDS)	Amount of Financial Assistance	Frequency of Assistance (monthly, annually, etc.)	Dates Received

Has a parent or child in the home lost a job in the past three months? *Yes No If yes, please complete the following:*

Name of Person(s) Who Lost Job	Date Job Lost	Former Employer's Name	Former Employer's Address & Phone Number	Severance Amount & Term

If there is employment history or other circumstance that you would like to be taken into consideration, please explain:

_____

Updated 1-1-2020

Case Management (Current Client)

Jewish Family SERVICES

List All Sources of Income and Provide Substantiating Documentation:

Type	Name of Person Who Receives Other Income	Amount Received	How Often Received (monthly, weekly, etc)
Total Monthly Income (from previous page)	See previous page		
SSI			
Social Security (Age/Disabled/Survivor)			
TANF			
Food Stamps			
Alimony			
Child Support			
Unemployment			
Family Assistance			
Trusts			
Dividend/Interest Income			
Savings/IRA			
Real Estate			
Other (list)			
Total Monthly Income			

List All Monthly Expenses

Item	Company	Amount Paid	How Often Paid
Rent/Mortgage (incl. taxes)			
Electric			
Gas/Bus Fare, Etc.			
Water			
Groceries			
Dining Out			
Child Care/After School Care			
Child Support Paid			
Telephone (wireless/home phone)			
Internet			
Cable			
Car Payment			
Car Insurance			
Car Maintenance			
Medical/Health/Dental Insurance			
Prescription Costs			
Other Medical Hardships			
Special Needs Services/Therapies (OT, PT, Speech)			
Home Owner's/Renters Insurance			
Home Owners Association Dues			
Life Insurance/Other Insurance			
Entertainment			
School Expenses (tuition, supplies)			
Membership (JCC, Temple, etc.)			
Clothing			
Pet Expenses			
Student Loans			
Credit Card			
Bank Loans/Other Loans			
Other (gym membership, personal hygiene, diapers, cleaning, repairs, paper products, haircuts, cigarettes)			
Total Monthly Expenses			

Total Monthly Income _____

Less Total Monthly Expenses: $_____

Surplus (Deficit): $_____

By signing below, I certify that I have answered the questions above honestly and accurately.

_____ Date_____/_____/_____

Signature of JFS Client

_____

Updated 1-1-2020

Printed Name of JFS Client