"WE GO THE EXTRA MILE TO PROVIDE QUALITY CARE."

2714 Canal Street, Ste. 316 New Orleans, Louisiana 70119

Please complete this form legibly. If you need assistance, or have a disability requiring special provisions, please call our office at 504-899-8100.

Client Name: ____
Last First M.I.

SSN: ______________________ D.O.B. _______________ Age: ________ Sex: _____

Phone Number: ____________________ Application Date: ________________

Ethnicity: ________________ Primary Language: ______________________

Home Address: ____
Street City, State Zip Code

List the issue(s) for which you are seeking help.

1.	4.
2.	5.
3.	6.

Health Coverage

Medicaid Status: _______ Current ____ Eligible _______ Application Pending _____ Not Insured

Primary Medical Plan: ____________________ Policy Id # ______________________

Secondary Medical Plan: ___________________ Policy ID # ______________________

Referral Information

List the person making the referral: ______________________________________
Name Title

Address: ____
Street City, State Zip

Phone Number: ________________________ Email: ______________________

Relationship to Client: ________________________

FOR SCN USE ONLY
Date Received:
SCN Counselor: