Baton Rouge

Sickle Cell Anemia Foundation

CLIENT ASSESSMENT FORM

PERSONAL INFORMATION

Name: _____ **Type of Sickle Cell Disease:** _____

Name of Parent/Guardian, if applicable: _____

Address: _____

State: _____ **Zip Code:** _____ **Parish:** _____

Contact Information: **Telephone Numbers: Home/Work/Cell** _____/_____/_____

E-mail address: _____

Date of Birth: _____/_____/_____ **Social Security Number:** _____
(provide copy of birth certificate) **(provide copy of social security card)**

Marital Status: (check one) _____Single _____Married _____Divorced _____Widowed

Race: (check one) _____Black _____White Other_____ **Sex:** (check one) _____M _____F

If client is a student, indicate school: _____

FINANCIAL INFORMATION – Provide proof of income.

Total employment income: $_____

Other family income: $_____

Total household income: $_____

Do you receive any of the following:
___SSI? ___Social Security? ___Disability?

Total benefits income: $_____

Number of persons living in household: _____

Does family receive food stamps: _____Yes _____No **Amount: $**_____

MEDICAL INFORMATION – **Provide copies of medical/insurance cards.**

Medicaid Number: _____ **Medicare Number:** _____

Other Medical Insurance: _____**Yes** _____**No**

Name of Company:_____

Policy Number: _____

Number of persons living in household with sickle cell trait: _____

Number of persons living in household with sickle cell disease: _____

Family Members: include both parents

Name	**Age**	**Sex**	**Disease/Trait**

Doctor's Name: _____

Hospital currently used: _____

List current medications:

_____ _____

_____ _____

_____ _____

SERVICE INFORMATION

Member of support group? _____**Yes** _____**No** **Attend meetings?** _____**Yes** _____**No**

Name of support group: _____

What services will you require?

_____ _____

_____ _____

Date: _____ _____

Client's Signature