**SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY**

**INFORMATION/IDENTIFICATION RECORD FOR SIP HOMES**

**Instructions:**

1. Complete all applicable information on form at the time you become responsible for the care of this individual.
2. Complete valuables inventory on the reverse side of form.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | | | | Case #: | | | | |
| Home Name/Address: | | | | | | | | |
| Social Security #: | | Marital Status: | Veteran Status: | | Sex: | | | Date of Birth: |
| Date Moved In: | Date Moved Out: | | Medicaid #: | | | | Health Plan: | |
| Religious Preference: | | | | | | | | |
| \_\_\_Next of Kin or  \_\_\_Legal Representative: | | | | | | Phone #: | | |
| Address: | | | | | | | | |
| Responsible Agency  & Representative: | | | | | | Phone #: | | |
| Address: | | | | | | | | |
| Primary Physician: | | | | | | Phone #: | | |
| Address: | | | | | | | | |
| Preferred Hospital: | | | | | | Phone #: | | |
| Address: | | | | | | | | |
| Consulting Physician: | | | | | | Phone #: | | |
| Address: | | | | | | | | |
|  | | | | | |  | | |
|  | | | | | | | | |
| Insurance Information: | | | | | | | | |
| Burial Provisions: | | | | | | | | |

**INFORMATION/IDENTIFICATION RECORD**

INVENTORY OF VALUABLES

|  |  |  |
| --- | --- | --- |
| ITEM | **Date**  **Received** | **Date** Returned |
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