

02 Telehealth  
03 School  
09 Jail  
11 DBH Site

12 Home  
13 Age Specific Com  
15 Mobile Service  
16 Non-Traditional Service

17 Healthcare/Primary Care  
18 Client Job Site  
20 Urgent Care  
21 Inpatient

23 Emergency Room  
27 Field/OOC  
28 Non-Face-to-Face  
29 Homeless

30 Faith Based-Church  
33 Licensed Care Res Adult  
53 Other Community Location

55 Residential Care Community Location  
72 Satellite  
99 Other

DATE: BILLING TIME: LOCATION: SERVICE TYPE: **ASSESSMENT**

ALL ITEMS BELOW MUST BE COMPLETED (EVEN WITH N/A OR "NOT AVAILABLE").  
(complete on first or second visit; may be completed by LPHA or non-LPHA)

RESOURCE NEEDS (appropriate to client's desires and culture)

INCOME:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

FOOD:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

HOUSING:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

MEDICAL CARE:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

EDUCATION:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

WORK/VOLUNTEER WORK/PREPARATION FOR WORK:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

CHILDCARE:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

TRANSPORTATION:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

LEGAL ADVICE:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

IMMIGRATION ASSISTANCE:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

OTHER \_\_\_\_\_:  No need Describe need and recommendation/plan: \_\_\_\_\_  
\_\_\_\_\_  
 Client declines help at this time

Date: \_\_\_\_\_ Provider Signature: \_\_\_\_\_ Provider Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Client Printed Name: \_\_\_\_\_

**CLIENT RESOURCE EVALUATION**

**NAME:**

**Confidential Patient Information  
See W&I Code 5328**

**CHART NO:**

**DOB:**

**PROGRAM:**