VIKINGLAND COMMUNITY SUPPORT PROGRAM
1106 Broadway St.
Alexandria, MN 56308
320-763-6261
320-763-6749 Fax

ADMISSION TYPE	DATE	DISCHARGE
______________	________	________
______________	________	________

APPLICATION/REFERRAL

Name:______________________________ **Age:**__________ **SSN:**________________

Address:______________________________ **Race:**__________

Birth date:______________________ **Marital Status : M S D W**

Phone:______________________ **MA#**______________________

Religion:______________________ **Education level:** ______________________

Emergency contact:______________________ **Guardian:** ______________________

Address:______________________ **Address:** ______________________

Phone :______________________ **Phone:** ______________________

Psychologist:______________________ **Phone**______________________

Physician:______________________ **Phone:** ______________________

Psychiatrist:______________________ **Phone:** ______________________

Social Worker:______________________ **Phone:** ______________________

County:______________________

M.I. Diagnosis:____

Health History: Diabetes ( ) Emphysema ( ) Vision Loss ( ) Epilepsy ( ) CD ( ) Hearing Loss ( ) Heart Disease ( )

Other:______________________________ **Allergies:** ______________________________

Hospital Information:

Hospital Name	Admission Date:	Discharge date:
1.		
2.		
3.		

Applicants Funding Sources: MSA ( ) SS ( ) SSI ( ) VA ( ) Other:__________

Referral Source: ____

Reason for Referral: ____

PLEASE ATTACH THE FOLLOWING IF AVAILABLE:

Social History	YES ( )	NO ( )	Medical Assessment	YES ( )	NO ( )
Diagnostic Assessment	YES ( )	NO ( )	Psychological/Psychiatric Assessment	YES ( )	NO ( )
Discharge Summary	YES ( )	NO ( )			

Signature of Applicant: ____

Signature of Referent: ____