Referral to Indigent Program

This form is intended to be completed by facility staff member who is assuming responsibility for compliance with ***Health and Safety Code Section 7104***.

Decedent Name: Sex: \_\_\_\_\_

Date of Death: \_\_\_\_\_\_\_\_\_\_ Time of Death: \_\_\_\_\_\_\_\_\_ Place of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residence address: How long?

Mailing Address: Phone:

Date of Birth: Place of Birth: SSN:

Marital status: Race: Employer:

Military Service: Yes □ No □ Branch of Service

Honorable discharge: Yes □ No □ VA Documents: DD214 □ Other □

**If referral is made after death please complete the two lines below:**

Doctor signing Death Certificate: Doctor’s phone:

Where is body stored: Phone:

Prior residence if currently in a facility:

If in a facility, date admitted: Admitted from:

Who signed them in:

Relationship: Phone #:

Property/funds held at the facility:

**Income & Assets**

SSI Income $ SSA Income $ VA Income $ Other $

Checking Acct. □ Savings Acct. □ Balance $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Bank: \_\_\_\_\_\_\_

Acct. Number: Patient trust balance $

Rep Payee Account? Yes □ No □ If so, who: Phone #:

Medicare #: Medi-Cal #:

Other property (house, cars, etc.):

Is there a will? Yes □ No □ Location of Will

Is there a power of attorney? Yes □ No □ Who has a copy?

**NEXT OF KIN**

List identified next of kin:

Name: Relationship:

Address: Zip Phone

Name: Relationship:

Address: Zip Phone

Name: Relationship:

Address: Zip Phone

Person making this referral: Ph: (name and title)

Address:

I certify that I have made a diligent effort to locate the decedent’s next of kin. I also certify that I have completed the form with the most current and accurate information available.

Date: Signed: