



Referring Agency \_\_\_\_\_ Intake Date \_\_\_\_\_

Please fax to Deborah @ (505) 797-6074

## Bridge to Justice Provider Referrals

Please circle: *Cancer Client* *HIV/Aids Client* *MS Client* *Other*

### Client Information:

Hearing/Response Date \_\_\_\_\_

Client Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Telephone: \_\_\_\_\_  
Home Cell Work Message Other

Language Spoken:  
English  
Spanish  
Navajo  
Other Language  
\_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. #

City State Zip

County: \_\_\_\_\_  
County where Client needs Attorney

Client can travel outside of County  
Yes No

### Legal Problem:

Treating Physician: \_\_\_\_\_

Attorneys Contacted by Patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Financial Information:

Gross Monthly Income: \_\_\_\_\_ Number in Household: \_\_\_\_\_ Ages: \_\_\_\_\_

Source of Income:  
Employment SS Child Support Alimony Welfare Worker Comp. Unemployment Other \_\_\_\_\_

Other Adults' Income: \_\_\_\_\_ Assets other than Income: \_\_\_\_\_

Living Expenses:  
Rent \$ \_\_\_\_\_ Utilities \$ \_\_\_\_\_ Medical \$ \_\_\_\_\_ Groceries \$ \_\_\_\_\_ Child Support Outgoing \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

Insurance Coverage:  
Company Employee Individual Government No Coverage

Medical Expenses: \_\_\_\_\_