MEDICAL-LEGAL PARTNERSHIP REFERRAL FORM: COMPLEX CARE

Name of Referring Health Care Provider:

Email and/or Phone Number of Referring Health Care Provider:

Today's Date:

1. Identify the Problem for Which the Patient Seeks Legal Assistance and Whether This Form Should be Faxed to Duke Children's Law Clinic or to Legal Aid of North Carolina

LEGAL MATTERS NOT HANDLED BY THE MEDICAL-LEGAL PARNTERSHIP

The MLP does **NOT** handle **criminal cases, traffic tickets, personal injury, or immigration matters**. Please refer patients/families with those problems or any other legal issue not listed below to the **Lawyer Referral Service of the NC Bar Association** at 1-800-662-7660 (also available in Spanish). Patients who need assistance with **child support enforcement** should be referred to one of two places. If they do not yet have court-ordered child support, they should be referred to the **Child Support Enforcement Office** of their local county's **Department of Social Services**. Patients who already have court-ordered child support should be referred to the relevant **court through which they obtained that order**.

LEGAL MATTERS THAT MAY BE HANDLED BY DUKE CHILDREN'S LAW CLINIC

IF THE PATIENT'S LEGAL PROBLEM IS AMONG THOSE LISTED BELOW, SEND THIS FORM VIA FAX TO CRYSTAL GRANT & PEGGY NICHOLSON
Fax: (919) 613-7262, Phone: (919) 613-7169

Education
- ☐ Special Education
- ☐ Suspension or Expulsion
- ☐ Other Education: (please explain on next page)

Benefits FOR CHILDREN**
- ☐ Medicaid or NC Health Choice for children
- ☐ Supplemental Security Income (SSI) for children
- ☐ Food Stamps/Nutrition Assistance for children

LEGAL MATTERS THAT MAY BE HANDLED BY LEGAL AID OF NORTH CAROLINA

IF THE PATIENT'S LEGAL PROBLEM IS AMONG THOSE LISTED BELOW, SEND THIS FORM VIA FAX TO JENNA LONG & CHARLY GILFOIL
Fax: (919) 682-8157; Phone: (919) 226-5916

Housing
- ☐ Mortgage Foreclosure
- ☐ Eviction
- ☐ Loss of Housing Subsidy, Public Housing
- ☐ Repairs/Unsafe Conditions in Rental Housing

Domestic Violence
- ☐ Domestic Violence Protective Order

Benefits FOR ADULTS**
- ☐ Medicaid for adults
- ☐ Disability Income (SSI or SSDI) for adults
- ☐ Food Stamps/Nutrition Assistance for adults/ families
- ☐ Unemployment
- ☐ Veteran's benefits

***** Note: LANC does not assist with applications for benefits. We may be able to assist adults whose applications have been denied or whose benefits or services have been terminated or denied. *****

2. Identify Any Legal Deadlines or Emergencies

- Have court papers been received? ☐ Yes. If so, when?

Name of family/ household member listed on court document?

- Is there a hearing or appeal deadline within 10 days? ☐ Yes. If so, when?
- Is there another legal emergency? ☐ Yes. If so, what?

3. Patient/ Family Information **Please review <u>all</u> information with your patient/family member prior to sending this referral**

- **Patient's Name:**
- **Patient's Date of Birth:**
- **If Patient is under age 18:**

  Parent's or Representative's Name:

  Parent's or Representative's Date of Birth:
- **Home or Mailing Address(es):**

  Can we send mail to this address? ☐ YES ☐ NO (Please ask, this is a matter of safety for some people.)
- **Phone Numbers** (***Please provide as many as possible***):

  Can we leave messages at each of these numbers? ☐ YES ☐ NO (Again, please ask as a matter of safety.)
- **Email address:**
- **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____

4. Other Information About the Legal Problem

- **Information About the Adverse Party** (E.g., School, Agency, Landlord, or Other Person Involved in the Legal Problem/ Dispute). Please include the **Full Name**, **Phone Number, Address, and Birth Date (**for individuals**).**

  We must determine if we have any potential conflict of interest before we can complete the application process. We **will not contact the adverse party without applicant's permission**
- **Please provide any relevant facts to help us understand the legal problem.**

5. Consent for Referral and Follow Up

I authorize the health care provider named below and other health care providers at Lincoln Community Health Center to talk with the legal staff of the Medical-Legal Partnership (MLP) Program about my child's/ family's legal problem to see if they can help resolve the problem or refer me to other resources. I also authorize the legal staff of the Medical-Legal Partnership Program to discuss my child's/ family's legal problem with the health care providers at Lincoln Community Health Center if that might help to resolve the problem.

_____

Signature of Patient, Parent or Representative Today's Date

_____

Referring Health Care Provider's Signature