MEDICAL LEGAL PARTNERSHIP REFERRAL FORM: TARRANT COUNTY MLP

(817) 569-5609

Date: _____

Name of Referring Health Care Provider/Clinician:_____

Department of Person Making the Referral: _____

Phone Number and **Email** of the Referring Provider:_____

LEGAL MATTER NOT HANDLED BY THE MEDICAL-LEGAL PARTNERSHIP

This MLP does **NOT** handle **criminal cases, traffic tickets or personal injury.** Please refer clients with those problems or any other legal issue not listed below to Lawyer Referral Service of the State Bar of Texas at 1-800-252-9690 (also available in Spanish).

1. Patient/Family Information: ***please review all information with the client/family member prior to sending this referral****

Client's Name: _____

Client's Date of Birth: _____/_____/_____ Male: ____ Female: ____ Race: _____

- **If Client is under age 18 or an incapacitated adult:**
  - Parent's or Representative's Name:_____ Relationship to Client: _____
  - Parent's or Representative's Date of Birth: _____/_____/_____

Client's Social Security Number: _____ Are you a Veteran: _____

Number of people in your household? Adults: __ Children: ____ Married:__
Widowed:__
Single:__
Divorced:__

Gross **Monthly** income: _____

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 #1:_____ Phone #2:_____

E-Mail:_____ Best Time of Day to Reach: _____

Can we leave messages at each of these numbers? Yes____ No ____ (Please ask, this is a matter of safety for some people.)

Are you a Citizen of the US: _____Preferred Language: English ____ Spanish _____ Other _____

2. Legal issue(s) (check all that apply):

☐Housing ☐ Guardianship ☐ Supplemental Security Income (SSI) ☐ Medicare/Medicaid

☐ Social Security Disability Income (SSDI) ☐ Expungement/Non-Disclosure ☐ Food Stamps
☐Other:_____

Is this matter URGENT? ☐Yes ☐No

If Yes, why? _____

3. **Other Information About the Legal Problem**

☐ Full Name of Adverse Party (E.g., Potential Guardian, Agency, Landlord or Other Person Involved in the Legal Problem/Dispute):_____

☐ Contact Information for the Adverse Party, Including Phone Number Address, and Birth Date:_____

☐ Provide a brief description of the client's legal needs:_____

_____

For Completion by the Applicant for Legal Services

4. Consent for Referral and Follow-Up

I wish to be referred to Tarrant County Medical-Legal Partnership so that I can apply for free legal services. As part of the referral process, I consent to the above information and this form being provided to Tarrant County MLP. I authorize the legal staff of the Medical-Legal Partnership Program to discuss my legal problem with my MHMR Provider if that might help to resolve the problem. I understand that this referral does not guarantee that Tarrant County MLP will be able to provide me with legal services.

Signature of Client, Parent or Representative:_____ Date: _____/_____/_____

IF THIS FORM IS BEING COMPLETED ELECTRONICALLY, PLEASE NOTE THAT APPLICANT GAVE VERBAL CONSENT AFTER BEING READ THE COMPLETE STATEMENT ABOVE AND PROVIDE THE DATE**Please send completed form to Tarrant County MLP case intake: email: tarrantcountymlp@mhmrtc.org**