Date: ________________________________
Patient/Client ID: _____________________
Collector Initials: _____________________

Gift Card Mailing Information Form

NOTE: Ask the client this information at the follow-up interview and then update the SOR/SOS iPortal locator form online. The asterisk * shows data required in the portal.

*Primary Phone: ______________________________ Can we text: Yes___ No___

Email Address: ___________________________

Mailing Address (Please indicate where the gift card will be sent to)

☐ Client's Address

☐ Client's Family or Friend Address

☐ Agency's Address

☐ Client does not have an address and therefore will not be sent a gift card

***Mailing Address**

Street: _______________________________________ City: _______________________________

State: _________________ Zip Code: __________________________

Second Address (Optional)

Street: _______________________________________ City: _______________________________

State: _________________ Zip Code: __________________________