02/2002

# MEDICAID WAIVER CLIENT INTAKE FORM

INTAKE DATE: _____ CLIENT'S PHONE #- _____

CLIENT'S NAME: _____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ ZIP: _____

COUNTY OF RESIDENCE: _____ D.O.B. _____

CLIENT IS AT: ☐HOME ☐HOSPITAL ☐OTHER MEDICAID #- _____

MEDICARE #- _____ SOCIAL SECURITY #- _____

CONTACT PERSON: _____ RELATIONSHIP TO CLIENT: _____

PHONE #- _____

DIRECTIONS TO CLIENT'S RESIDENCE: _____

_____

_____

REFERRAL SOURCE: _____ PHONE #- _____

PHYSICIAN: _____ PHONE #- _____

ADDRESS: _____ CITY: _____ ZIP: _____

DIAGNOSIS: _____

DIET: _____

SERVICES NEEDED: ☐ In-Home Respite ☐ Institutional Respite ☐ Adult Day Care ☐ Home Health
☐ Homemaker ☐ Home Delivered Meals ☐ Escorted Transportation

CURRENT SERVICES/PROVIDERS IN PROGRESS:

| DISCIPLINE | FREQUENCY | PROVIDER |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

DEFICITS IN ADL'S
☐ EATING
☐ TOILETING
☐ BATHING
☐ PERSONAL HYGIENE
☐ AMBULATION
☐ TRANSFERRING
☐ DRESSING

ADDITIONAL PERTINENT INFORMATION/SPECIAL NEEDS: _____

_____

FOR OFFICE USE ONLY:

VERIFICATION OF MEDICAID STATUS: ☐YES ☐ NO DATE: _____ LOCK-IN STATUS: _____

DATE REFERRAL RECEIVED: _____

DATE CLIENT CONTACTED: _____ BY WHOM: _____