MEDICAID WAIVER CLIENT INTAKE FORM

INTAKE DATE: _____ CLIENT'S PHONE#: _____

CLIENT'S NAME: _____ MALE OR 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: _____
CONTACT PHONE #: _____

DIRECTIONS TO CLIENT'S HOME:

_____

_____

_____

_____

REFERRAL SOURCE: _____ PHONE#: _____

PHYSICIAN: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ ZIP _____

DIAGNOSIS: _____ DIET: _____
DEFICITS IN ADL'S: __EATING __TOILETING __BATHING __ PERSONAL HYGIENE __AMBULATION __TRANSFERRING __DRESSING

SERVICES NEEDEDED: __ HOMEMAKER __ HOME DELIVERED MEALS __ IN HOME RESPITE __ ESCORTED TRANSPORTATION
__ ADULT DAY CARE __ HOME HEALTH __ INSTITUTIONAL RESPITE

CURRENT SERVICES/PROVIDERS IN PROGRESS:

DISCIPLINE	FREQUENCY	PROVIDER

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: _____