MEDICAID WAIVER CLIENT INTAKE FORM

INTAKE DATE: _____ CLIENT'S PHONE#: _____

CLIENT'S NAME: _____ PatID: _____ ☐ 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: _____

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 ☐ Extended Home Health ☐ Personal Care Service ☐ Home Delivered Meals

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: _____