Intake and Referral Form

DATE: ____________________________

CALLER INFORMATION:

Name: ____

Address: _________________________City: _________________State:______ Zip:_____

County: __________________________

Telephone: ____________________________ Cell: ______________________________

The person that I am calling about is:
_____Myself _____Mother _____Father _____Spouse _____Partner _____Child <18
_____Child >18 _____A relative _____A friend _____Other ___________________

Why are you calling today? ____

____

____

How did you hear about us?

____

CLIENT INFORMATION:

Name: _______________________________________ D.O.B. _________________________

Address: ____

City: ________________________ State: ____ Zip: ________ County: ___________________

Home Phone: ____________________________ Cell: ______________________________

SS# _____-_____-_______ Gender: ____ Male ____ Female

Marital Status: _____Married _____Divorced _____Never Married _____Widowed

_____Separated _____No Information given

Is there anyone who helps the client make decisions?

_____Legal Guardian _____POA _____DPOA

Name: __________________________________

Contact Information: ____

Is the client currently receiving services/support from anyone? _____ Yes _____No

If yes, who and what services: ____

____

Intake and Referral Form

CLIENT LIVING ARRANGEMENTS:

_____Alone _____With Relatives _____With others _____ Independent w/supportive services

_____Group Home _____Assisted Living _____Hospital (date of admission ___________)

_____ Nursing Facility (date of admission __________) _____Animals in the home? ________

CLIENT HEALTH INFORMATION:

Does the client need 24 hour care? ___Yes ___No

If yes, are they receiving it? ___Yes ___No

Has the client ever been diagnosed with the following?

_____ Diabetes _____Hypertension (High Blood Pressure) _____COPD _____Pneumonia

_____ CHF (Congestive Heart Failure) _____CVA (Stroke) _____ Dementia or Alzheimer's

_____ Arthritis _____Kidney Failure _____ Schizophrenia _____ Depression _____Anemia

_____ Other: ____

____

____

Has the client ever been determined by the Government to be disabled? ____Yes ____No

Primary Disability:

_____Blind/Visual Impairment _____Hearing, Speech & other Sensory Impairment

_____Spinal Cord Injury _____Mobility Orthopedic Disability/Amputation

_____Mental/Emotional Illness _____Alcohol/Drug _____Developmental Disability

_____Cognitive Disability _____Traumatic Brain Injury _____Other:______________________

CLIENT ACTIVITIES OF DAILY LIVING

How does the client accomplish the following?

Bathing	___Alone	___With help
Dressing	___Alone	___With help
Eating	___Alone	___With help
Grooming	___Alone	___With help
Mobility		
Bed Mobility	___Alone	___With help
Walking	___Alone	___With help
Transfer	___Alone	___With help
Toileting	___Alone	___With help

Is the client able to do the following?

Use the telephone	___Yes	___No
Heavy chores	___Yes	___No
House cleaning	___Yes	___No
Yard work/Maintenance	___Yes	___No
Laundry	___Yes	___No
Meal Preparation	___Yes	___No
Shopping	___Yes	___No
Drive	___Yes	___No

Does the client have access to transportation?	___Yes	___No
Administer medications for them self?	___Yes	___No

Intake and Referral Form

CLIENT MEDICAL INSURANCE

_____ Medicare #_________________________________

_____ Medicaid #_________________________________

_____ Private Group Insurance Name: __________________________________

_____ Medicaid HMO ___Unison ____ Molina ___Care Source ___Other_______________

CLIENT BENEFIT ENROLLMENT

Is the client currently receiving any of the following benefits?

___Veterans ____SSI ____TANF ___Food Stamps ___SSDI ___WIC ___Subsidized Housing

___ SSDAC ___ Unemployment ___ Workers Comp ___ QMB ___ SLMB ___QI ___Part D

___ Medicare Rx Extra Help ___HEAP ___ Medicaid for Aged, Blind, Disabled

___State Property Tax Relief/Rebates (Homestead Exemption)

___Telephone Discount Assistance (Link-up and Lifeline)

FUNDING SOURCES AND WAIVER SERVICES

Is the client currently enrolled in any of the following programs?

___PASSPORT ___Under 60 Waiver ___RSC (Rehabilitation Service Commission)

___Developmental Disability ___WIA (Workforce Investment Act) ___RSS

CLIENT EMPLOYMENT AND INCOME

Employment Status:

___Full time ___ Unemployed-Seeking ___Unemployed-Not Seeking ___Retired

Client Monthly Gross Income: $_____________ Source: ________________________

VERBAL RELEASE OF INFORMATION:

Verbal release to contact Physician ___ Yes ___ No

Physician Name: ___________________________________

Address: ____

Phone: ____

Verbal release to contact other agencies. ___Yes ___ No

Intake and Referral Form

OUTCOME:

___ **Assessment Scheduled** Date: ________________________________

___ PASSPORT ___ LTCC ___LOC ___ Homestead LOC

___ Delayed Assessment ___ PAS/ LOC

Will caregiver be available for Assessment? ___ Yes ___ No

Please have available for the Assessment: (1) Financial information (2) Medications

Please tether all animals during time of LTCC.

___ **Forward unmet needs to SE Ohio ADRN** (AAA8 Planner's mailbox)

___ **Referred to:** ____

Comments:

____

____

____

____

____