MEDICAID WAIVER CLIENT INTAKE FORM

INTAKE DATE: _____ CLIENT'S PHONE: _____

CLIENT'S NAME: _____ □ MALE □ FEMALE

ADDRESS: _____ CITY _____ ZIP: _____

COUNTY OF RESIDENCE: _____ DOB: _____

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 □Home Health
□Personal Care Service (PCS) □Home Delivered Meals □Non Emergency Transportation (NET)

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: **Estate Recovery Explained:** □Yes □No

Verification of Medicaid status: □Yes □No Date: _____ Lock in Status: _____
Date Referral Received: _____ Date Client Contacted: _____ By Whom: _____