

Fax To: INTAKE Department

Fax:

Type of Request:	<input type="checkbox"/> Comprehensive Assessment	<input type="checkbox"/> Nursing Home Placement	<input type="checkbox"/> Assisted Living
Referent: _____			
Agency: _____			
Phone: _____			
Pager: _____			
CLIENT Name: _____			
Address: _____			
Phone:	Zip (H)	Street (W)	City County Zip
PRIMARY CONTACT			
Name: _____ Relationship: _____			
Address: _____			
Phone:	Street (H)	City (W)	County Zip
LEGAL Guardian: <input type="checkbox"/> YES <input type="checkbox"/> NO POA: <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name: _____ Relationship: _____			
Address: _____			
Phone:	Street (H)	City (W)	County Zip
DEMOGRAPHICS: SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____			
SS# _____ Medicaid# _____ Medicare# _____			
Other Insurance? Medicare HMO: <input type="checkbox"/> YES <input type="checkbox"/> NO			
PHYSICIAN's Name: _____			
Address: _____			
Phone:	Street	City	County Zip
Fax: _____			
Language / Communication Barrier: <input type="checkbox"/> YES <input type="checkbox"/> NO (hard of hearing / confused / aphasia / language[s] spoken)			
Language / Communication Issues: _____			
DIAGNOSIS: Primary: _____			
Other: _____			
Is there a diagnosis of dementia, Alzheimer's, organic mental disease, mental illness, MR/DD? <input type="checkbox"/> YES <input type="checkbox"/> NO			
FUNCTIONAL (check all that apply)		FINANCIAL	
<input type="checkbox"/> Age _____ PASSPORT 60+ Assisted Living 21+		_____ Consumer's Monthly Income	
<input type="checkbox"/> Needs hands-on help with ADL's (Bathing, Grooming, Dressing, Toileting, Mobility/Transferring, medication Assist)		_____ Consumer's Assets	
<input type="checkbox"/> Needs hands-on help with IADL's (Banking, Phone, Meal Prep, Laundry, Shopping Transportation)		_____ Joint Assets	
<input type="checkbox"/> Needs 24 Hour Supervision due to Dementia		Transfer of Assets <input type="checkbox"/> YES <input type="checkbox"/> NO (within past 3 years)	

