

SARPC/AAA Intake/Referral**CLIENT INFORMATION**

Call: 706-4680 or Fax: 706-0896

Name		Social Security #		Medicaid #	
Address		City	County	Zip Code	Telephone #
Date of Birth	Doctor Name	Last Visit	Telephone		

Can we contact the client?

Can we contact the referral source?

The caregiver?

Source of Income

☐ SS ☐ Full Medicaid ☐ SSI ☐ Deeming ☐ QMB/SLMB/QI ☐ Pension ☐ Medicare Part A B C D

Does client have any of the following?

☐ AIDS/HIV	☐ Arthritis	☐ COPD	☐ HTN	☐ Parkinson	☐ Alcohol/Drug
☐ Mental Illness	☐ Renal Failure	☐ Alzheimer's	☐ Cancer	☐ Diabetes	☐ CHF ☐ Dementia
☐ Mental Retardation	☐ Seizure	☐ Amputation	☐ Heart Disease	☐ Paralysis	☐ Blindness
☐ Falls	☐ CVA	☐ Asthma	☐ Obesity >>>>>>Weight _____	Height _____	
☐ Cane	☐ Walker	☐ Wheelchair	☐ Oxygen	☐ Hoyer Lift	
☐ CD 4 Count _____	☐ Viral Load _____	☐ Other _____			

☐ Recent Hospitalization (date/s) _____ ☐ NH (discharge date) _____

Current Services in the Home

☐ Home Health ☐ Hospice ☐ DHR ☐ Other _____
CAREGIVER INFORMATION

Name		Relationship		Telephone #	
Address		City	State	County	Zip Code
Referral Source		Relationship		Telephone #	
Name of Intake Person		Telephone #	Client Referred to...		Date

Comments: