AgeSouth SARPC AGENCY ON AGING

Alabama Department of Senior Services Elderly and Disabled Medicaid Waiver Program

Intake/Referral

CLIENT INFORMATION

Name	Social Security #	Medicaid #

Address	City	County	Zip Code	Telephone #

Date of Birth	Doctor Name	Last Visit	Telephone	Race / Gender / Marital Status

Source of Income & Amount

Income Amount $_____

☐ 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
☐ Mental Retardation ☐ Seizure ☐ Amputation ☐ Heart Disease ☐ Paralysis ☐ Blindness
☐ Falls ☐ CVA ☐ Asthma ☐ Obesity >>>>>> Weight _____Height_____

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

☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen ☐ Hoyer Lift ☐ Other _____

Current Services in the Home

☐ Home Health ☐ Hospice ☐ DHR ☐ Other_____

CAREGIVER INFORMATION

Name & Date of Birth	Relationship	Telephone #

Address	City	State	County	Zip Code

Referral Source	Relationship	Telephone #

Name of Intake Person	Telephone #	Client Referred to…	Date

Comments: