ADRC Participant Intake Form

MIG Score: . MIG Date: Options Counseling: .

Date of Referral: Time: . Completed by Intake Staff:

Referral Source Information:

Caller Name: . Phone:

Caller Address: City: State: Zip:

Relationship to Participant* :

If the caller is not the participant, ask: "Did the Participant give you permission to make this referral?": ☐ Yes ☐ No

Participant's Information:

Name: D.O.B: Assigned Sex at Birth: ☐ M ☐ F ☐ H

Address: City: State: Zip:

Phone: Needs Communication Support : Marital Status :

U.S. Veteran? : Ethnicity & Primary Race : :

Lives with (select all): ☐ Alone ☐ Spouse ☐ Other Relative: ☐ Non-Relative Name:
☐ Child ☐ Parent ☐ Friend: ☐ *SNF/AFC/HFA:

What are the primary diagnosis or health concerns that you feel are important for Care Management to be aware of?

When the participant cannot be contact by phone (e.g.,Alzheimer's, HOH, Speech) who should receive the follow-up calls?

Contact Individual

Alternate Contact Information:

Name of Alternate Contact:	Phone (s):	Relationship:	Select all that apply:
			☐ Alternate Contact ☐ Rep.Payee

Address: C/S/Z: ☐ Guardian ☐ DPOA

If a caregiver, specify care being provided: ☐ Emergency ☐ APS

Current Facility Information:

Facility Type: ☐ Hospital ☐ SNF ☐ ALF ☐ AFC Date Admitted: Discharge Date (if known): .

Name of Facility: Room Number: Room Telephone:

Reason for Admission:

Skilled Nursing Facility Residents Only:

Initial Discharge Plan: ☐ Medicare Rehab Stay *-Planned discharge date:* ☐ Medicaid Long-term Placement ☐ Other:

Do you believe the participant will need waiver services? :

If YES, what door do they qualify under? :

If a temporary door (3-5), to what date will they be eligible?:

Is this referral being made in regards to the MDS Section Q Assessment? :

Paying Source:

Person hospitalized before admission? : *If "Yes," Date?:*

Insurance Information:

Types of Insurance: ☐ Unknown ☐ None ☐ Veterans ☐ Medicaid ☐ Market Place ☐ Employer ☐ Workers Comp. ☐ LTC Ins.

☐ Medicare(select all that apply): ☐ Part A ☐ Part B ☐ Part C ☐ Part D ☐ Medicare Supplement ☐ Other Insurance:

Original Medicare Number: . Insurance Group Number: .

Social Security Number: . Receives SSDI? . Medicaid Number: .

Name: _____

Current Provider Services: *(Select all with hours in use or pending)*

☐	Skilled Nursing:	___ X	: _____	☐	Homemaker Chore Services:	___ X	: _____
☐	Physical Therapy:	___ X	: _____	☐	Personal Care & Hygiene:	___ X	: _____
☐	Occupational Therapy:	___ X	: _____	☐	Respite Relief:	___ X	: _____
☐	Speech Therapy:	___ X	: _____	☐	Home Delivered Meals:	___ X	: _____
☐	Personal Alarm System:	___ X	: _____	☐	Medication Delivery:	___ X	: _____
☐	DHHS Home Health Services:	___ X	: _____	☐		___ X	: _____

Primary Health Concerns:

ADL TASKS:	IADL TASKS:	COGNITIVE ISSUES:	Additional Statements from Caller:
☐ Ambulation	☐ Housework	☐ Daily Decision-Making	
☐ Bathing	☐ Shopping	☐ Memory Loss	
☐ Dressing	☐ Taking Medication	☐ Dementia	
☐ Bowel/Bladder	☐ Transportation		
☐ Transferring	☐ Using Telephone		

MI Choice Screen Notes:

Financial Status Review:

			Other:
Individual's Monthly Income:	☐ Above $2,742	☐ Below $2,742	. _____
Single Assets:	☐ Above $2,000	☐ Below $2,000	. _____
Married Assets:	☐ Above $29,724	☐ Below $29,724	. _____

Select All Referrals Made During Screen:

☐ Elder Law/General Legal	☐ MMAP	☐ Veteran Assistance
☐ Home Delivered Meals	☐ Respite Relief	☐ Yardwork/Repairs
☐ Homemaker Tasks	☐ Skilled Nursing	☐ _____
☐ Housing	☐ Transportation	☐ _____