

Intake and Referral Form –
All In-Home & Community-Based Service Programs

Name _____ Date _____

Address _____

Phone _____ SSN _____ Birthdate _____

Military Veteran _____ Household Size _____ Medicaid # _____

Other Insurance Name and Policy Number: _____

Primary Physician _____ Phone _____

Who Called _____ Relationship _____

Phone _____

Emergency Contact _____ Relationship _____

Address _____

Phone _____ Does client have a guardian/POA _____

Type of Assistance Needed _____

Medical Conditions _____

E-screen

Individual is unstable and has any of the following conditions:

Requires direct assistance at least 3x per week

- Ventilator
- Tube/Gastrostomy
- Suctioning
- Central venous or I.V.

Requires direct assistance at least 5x per week

- Decubitis Ulcer stage 3 or 4
- Comatose
- Management of severe pain req. more than one injection daily
- Tracheotomy
- Acute rehab for new condition within 6 mos. (general strengthening excluded)
- Oxygen for new condition req. nursing asst.
- Direct assistance to administer shots including insulin
- Condition is unstable and req. visits to physician at least every 30 days for monitoring
- Grand Mal seizure with activity at least 1x per week.

Individual is stable but needs assistance due to or with the following:

- Daily monitoring of fluid intake/output
- Direct assistance with oxygen for stable condition
- Direct assistance daily with administering of medications
 - Who is helping you now?
- Requires 24 hour supervision due to confusion/disorientation
- Requires direct assistance to turn/reposition every 2-4 hours
- Passive range of motion exercises daily which require direct assistance
- Eating
- Transferring
- Dressing: Who is helping you now?
- Bathing : Who is helping you now?
 - Would a shower chair help?
- Incontinent requiring direct assistance
- Ambulation/ recent or history of falls
 - How often do you fall?
 - When was the last time you fell?
 - What causes you to fall?

Income

Wages _____ Interest bearing accounts _____
SS Retirement _____ Worker's Comp _____
Social Security Disability _____ Rental Income _____
SSI _____ Short/Long term Disability Insurance _____
Income of Parents or Spouse _____ Other income _____
Veteran's _____ Pensions _____
Child Support _____ Alimony _____

Deductions

Health Insurance Premiums _____ LTC Insurance _____
Medical Care _____ Psychological Care _____
Medicare Premiums _____ Unpaid Medical Bills _____
Medications _____ Client Paid Services _____
Other _____

Subsidies

TANF _____ Energy Assistance _____
Food Stamps _____ Housing Subsidies _____
Child Care _____ Weatherization _____

Assets

Savings _____ Stocks/Bonds _____
Life Insurance with cash value _____ Checking Account _____

Nutrition questions

- 1) Is there an illness or condition that has changed the kind and/or amount of food you eat? Yes is 2 points
- 2) Do you eat fewer than 2 meals per day? Yes is 3 points
- 3) Do you include fruits, vegetables, and milk in your daily diet? No is 2 points
- 4) Do you drink 3 or more drinks of beer, liquor, or wine almost every day? Yes is 2 points
- 5) Do you have tooth or mouth problems that make it difficult to eat? Yes is 2 points
- 6) Do you have the money you need to purchase the food you need? No is 4 points
- 7) Do you eat alone most of the time? Yes is 1 point
- 8) Do you take 3 or more different prescribed or over the counter medications a day?
Yes is 1 point
- 9) Without warning or trying have you gained or lost 10 lbs in the last 6 months?
Yes is 2 points
- 10) Are you always physically able to shop, cook, and or feed yourself? No is 2 points
High Nutritional risk is 6 or more points

Housing Questions

- 1) Type: House Apartment Mobile Home Other _____
- 2) Ownership: Own Rent Subsidized Other _____
- 3) Is your housing adequate?
- 4) Do you have working smoke detectors?
- 5) Is housing handicapped accessible?

Formal Support

HHC _____

Private Pay _____

Hospice _____

Informal Support

Name, Frequency, Phone, and task

Medications

Pharmacy _____

Able to take medications?

Patient Non Complaint?

Preparation needed?

Must be administered?

Difficulty paying for medications?

Hospitalizations

Reason, Hospital, Dates:

Transportation

Does client drive?

Are escort services needed?

Requires wheelchair accessibility?

Transportation source: _____

Treatments

Type, frequency, provider

Institutional Placements

Has client been placed in a NF previously? Yes No

Facility and dates: _____

Psycho-Social

Hallucinations? None Auditory Tactile Visual

Is client abusive? No To Self To Others

Suicidal Thoughts? Does the client experience depression?

Alcohol or Substance abuse? No Alcohol Substance

Smokes Carelessly? Wanders?

Language and Misc

Does client speak English? Other language _____

Is the client currently employed? Needs assistance with laundry?

Does client have leisure time activities?

Does client have any of the following:

Poor eyesight Dental Problems Trouble sleeping Hearing problems

Isolation Experiencing major life crisis

Lives in a home with hazardous conditions

Generations 1019 N. 4th St.; P.O. Box 314 Vincennes, IN 47591
Attn. Options Counselors in the Link-Age / 2-1-1 Department – Fax: 812-888-4568

Special Needs:

Bed commode	Dentures	Dressing equipment	Employment
Glasses	Grab bars	Hearing Aid	Hospital bed
Oxygen	Pacemaker	Prosthesis	Incontinence supplies
Toilet equipment	Tub Stool	Walker	Transfer Equipment
Wheelchair	Cane		