AMLAB HOMES

CLIENT INTAKE FORM

INTAKE DATE: ---------- CLIENT PHONE NUMBER: ----------

NAME OF CLIENT: MALE ☐ ☐ FEMALE

ADDRESS: ----------CITY----------

ZIP: ----------COUNTY OF RESIDENCE----------DOB: ----------

CLIENT IS AT: ☐ OWN HOME ☐ AMLAB HOME ☐ FAMILY HOME

SOCIAL SECURITY #: ---------- MEDICAID #: ----------

CONTACT PERSON: ----------RELATIONSHIP TO CLIENT: ----------

CONTACT PERSON'S ADDRESS: ----------

---------- -CITY: ---------- - STATE: --------- ZIP CODE: ----------

PHONE NUMBER: ---------- EMAIL: ----------

REFERRAL SOURCE: ---------- PHONE: ----------

PHYSICIAN: ---------- PHONE: ----------

ADDRESS: ---------- CITY: ----------ZIP: -------

DIAGNOSIS: ----------

DIET: ----------

SERVICES NEEDED: ☐ COMMUNITY INTEGRATION AND HABILITATION:

☐ COMMUNITY TRANSITION ☐ PRE-VOCATIONAL SERVICES ☐ RESIDENTIAL HABILITATION AND SUPPORT ☐ STRUCTURED FAMILY AND CAREGIVING-LEV1-DDRS ☐ TRANSPORTATION-LEVEL 1 ☐ WORKPLACE ASSISTANCE

☐ FAMILY SUPPORTS WAIVER:

☐ PARTICIPANT ASSISTANT AND CARE ☐ PRE-VOCATIONAL SERVICES ☐ WORKPLACE ASSISTANCE

MONEY FOLLOWS PERSON---CIH TRANSFER:

☐ COMMUNITY TRANSITION ☐ PRE-VOCATIONAL SERVICES ☐ WORKPLACE ASSISTANCE ☐ RESIDENTIAL HABILITATION AND SUPPORT ☐ STRUCTURED FAMILY CAREGIVING -LEVEL 1 -DDRS ☐ TRANSPORTATION LEVEL 1

☐ RESPITE CARE

OTHER SERVICES NEEDED:

SPECIFY: ----------

ADDITIONAL PERTINENT INFORMATION/ SPECIAL NEEDS: (ADL DEFICITS: EATING, TOILETING,BATHING,PERSONAL HYGIENE,AMBULATION, TRANSFERRING, DRESSING). CIRCLE.

FOR OFFICE USE ONLY: VERIFICATION OF MEDICAID STATUS ☐ YES ☐ : NO

CASE MANAGER:
