

## Intake/Referral

**Serving Jefferson County ONLY**

Attn: Connie [medicaidwaiverreferral@rpcgb.org](mailto:medicaidwaiverreferral@rpcgb.org)

Office: (205) 623-3551

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NAME		ADDRESS & APT. #		CITY	ZIP
PHONE/CELL	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE / FEMALE / TRANSGENDER		
PHYSICIAN'S NAME		LAST MEDICAL APPT	PHYSICIAN PHONE #	MEDICAID #	
PRIMARY LANGUAGE (list below)					
English					

MEDICAL CRITERIA (please check)					
AIDS/HIV	Arthritis	COPD	HTN	Parkinson's	Legally Blind
Mental Illness Type:	Renal Failure	Asthma	Cancer Type:	Diabetes	Blood Clots
Alcohol/Drug (past or present?)	Intellectual Disability	Developmental Delay	Cerebral Palsy	Seizures/Epilepsy Last seizure:	Amputation
CHF	CVA (stroke) Date of stroke	Heart Disease	M.S. or M.D.	Paralysis	Neuropathy
Falls/Fall Risk	ALS (Lou Gehrig's)	Alzheimer's	Dementia	Huntington's	Severe Obesity Weight:

Other Health Issues/Diagnoses/Physical Limitations/Comments					

Recently Hospitalized?	Date:	Recently in Nursing Home?	Discharge Date:
Cane	Walker	Wheelchair	Hoyer Lift
		Oxygen	Dialysis

CURRENT SERVICES IN THE HOME			
Home Health	Hospice Paid by Medicaid or Medicare?	DHR	Other
Agency:		Agency Phone #:	
Services:			

SERVICES NEEDED IN HOME					
Homemaker	Personal Care	Unskilled Respite	Skilled Respite	Companion	Frozen Meals (21 & up)
Personal Choices Services (self-directed care)					
Is the member at Risk for nursing home placement? ( ) Yes ( ) No    Can the member be left alone? ( ) Yes ( ) No					
Does the member Live Alone? ( ) Yes ( ) No    Comments:					

CAREGIVERS/CONTACT INFORMATION		
NAME	RELATIONSHIP	PHONE/CELL
REFERRAL SOURCE	RELATIONSHIP/AGENCY	PHONE
NAME OF INTAKE PERSON	DATE	PHONE # OF AGENCY
		( )

FOR OFFICE USE ONLY			
Received Date:	MSIQ:	Entered in AIMS:	Entered in FamCare: