EARPDC'S
Home & Community
Based Service Program

Intake/Referral

Alabama Department of Senior Services Elderly and Disabled Medicaid Waiver Program

CLIENT INFORMATION

Name	Social Security #		Medicaid #	
Address	City	County	Zip Code	Telephone #

Date of Birth	Doctor Name	Last Visit	Telephone #

Source of Income

☐ SS ☐ Full Medicaid ☐ SSI ☐ Deeming ☐ Qmb/SMLMB/QI ☐ Pension ☐ Medicare Part A B C D

Does client have any of the following?

☐ AIDS/HIV	☐ Arthritis	☐ COPD	☐ HTN	☐ Parksinson	☐ 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 ______________

Does client have any of the following?

☐ Home Health ☐ Hospice ☐ DHR ☐ Other ______________________________

CAREGIVER INFORMATION

Name	Relationship		Telephone #	
Address	City	State	County	Zip Code

Referral Source	Relationship	Telephone #

Name of Intake Person	Telephone #	Client Referred to...	Date

Comments: