Regional Planning Commission of Greater Birmingham
Medicaid Waiver Program

Intake/Referral

CLIENT INFORMATION – Jefferson County ONLY

NAME	ADDRESS	CITY	ZIP

Telephone	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MEDICAID #
( )			

DOCTOR'S NAME/HOSPITAL	LAST VISIT	DOCTOR'S PHONE #	MALE	FEMALE
		( )		

Source of Income

( )SS ( )Full Medicaid ( )SSI ( )Deeming ( )QMB/SLMB/QI ( )Pension ( )Medicaire Part A B C D

MEDICAL CRITERIA (please check)					
AIDS/HIV	Arthritis	COPD	HTN	Parkinson	Alcohol/Drug
Mental Illness	Renal Failure	Alzheimer's	Cancer	Diabetes	CHF
M.R.	Seizures	Amputation	Heart Disease	Paralysis	Blindness
Falls	CVA (stroke)	Asthma	Dementia	M.S. **or** M.D.	Severe Obesity

Other Health Issues not mentioned above	
	W __________ H __________

Recent Hospitalized? Date:	Recent Nursing Home? Discharge Date:

Cane	Walker	Wheelchair	Hoyer Lift	Oxygen	Dialysis:

Current Services in the Home			
Home Health	Hospice	DHR	Other:

Agency:
Services:

More than $5000 in Life Insurance? **More than one property?** **More than $2000 in assets?**

SERVICES NEEDED IN HOME

HM	**PC**	**UR**	**SR**	**CO**	**Meals**

Physical Limitations:
Is Client at Risk:
Does Client Live Alone: ( )Yes ( )No Comments:

CAREGIVERS/CONTACT INFORMATION

NAME	RELATIONSHIP	TELEPHONE
1.		( )
2.		( )

Referral Source	Relationship/Agency	Telephone
		( )

Name of Intake Person	Date	Agency/Phone
		( )

Entered in AIMS:	MSIQ attached?

Comments:	**E/D Waiver**	**530 Waiver**