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| --- |
| Regional Planning Commission of Greater Birmingham  Medicaid Waiver: Elderly & Disabled Waiver Program**Intake/Referral** |

**Serving Jefferson County ONLY**

**Attn: Shammara Johnson, MSW** **sjohnson@rpcgb.org** **Office: (205) 623-3551 Fax: (205) 326-2121**

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

|  |
| --- |
| **MEDICAL CRITERIA (please check)** |
| AIDS/HIV | Arthritis | COPD | HTN | Parkinson’s | Legally Blind |
| Mental IllnessType:  | Renal Failure | Asthma | CancerType:  | Diabetes | Blood Clots |
| Alcohol/Drug (past or present?) | Intellectual Disability | Developmental Delay | Cerebral Palsy | Seizures/EpilepsyLast 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 ObesityWeight:  |
| **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 | HospicePaid 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:  |

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