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

**Serving Jefferson County ONLY**

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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’S PHONE # | | MEDICAID # | | |
|  | |  | | | ( ) | |  | | |
| **PRIMARY LANGUAGE (list below)** | | | | | | | | | |
|  | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | |

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