

RESIDENT INTAKE FORM

1. Identifying Information

Name: _____		Phone: _____	
Apt. # _____	Date of Birth: _____	Age: _____	
<input type="checkbox"/> male	<input type="checkbox"/> female		
Marital Status:	<input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		
Living Status:	<input type="checkbox"/> alone <input type="checkbox"/> w/frail spouse <input type="checkbox"/> w/well spouse <input type="checkbox"/> w/other		
Pet/Animal	<input type="checkbox"/> yes <input type="checkbox"/> no		

2. Emergency Contact Information

Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Relationship: _____	Relationship: _____ Cousin
Contact: <input type="checkbox"/> often <input type="checkbox"/> rarely <input type="checkbox"/> phone	Contact: <input type="checkbox"/> often <input type="checkbox"/> rarely <input type="checkbox"/> phone

3. Insurance Information

Social Security # _____	SSI/SSDI <input type="checkbox"/> yes <input type="checkbox"/> no
Medicaid # _____	<input type="checkbox"/> QMB <input type="checkbox"/> SLMB <input type="checkbox"/> Food Stamps
Spend down <input type="checkbox"/> yes <input type="checkbox"/> no _____	
Medicaid Caseworker: _____	
Medicare Supplement _____	
Veteran Status: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> widow	
Comments: _____	

4. Income Sources

Social Security _____/month
Retirement _____/month
Veterans _____/month
SSI _____/month
SSDI _____/month
Other _____/month

5. Other

Living Will: <input type="checkbox"/> yes <input type="checkbox"/> no	Resident has copy: <input type="checkbox"/> yes <input type="checkbox"/> no
Power of Attorney <input type="checkbox"/> yes <input type="checkbox"/> no	Name of POA: _____
Legal Guardian <input type="checkbox"/> yes <input type="checkbox"/> no	Name: _____
Doctor: _____	Phone: _____
Address: _____	Address: _____
_____	_____
Phone: _____	_____