

RESIDENT INTAKE FORM

Identifying Information

Name: _____ DOB: _____ Apt#: _____

Social Security# _____ Drivers License # _____ Exp _____

Phone _____ Company _____ Lifeline/LU _____

Marital Status _____ Pets/Animals () no () yes _____

Living Status: () alone () w/ spouse () w/ frail spouse () w/ other

Emergency Contact Information

Name: _____

Name _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Relationship: _____

Relationship: _____

Contact: () often () rarely () phone () visits

Contact: () often () rarely () phone () visits

Insurance Information

Medicare #, Type, Effective Date _____ M-Care Supplement () No () Yes

Medicaid # _____ Type: () Medical () QMB () SLMB () Spenddown _____

Medicaid Transport Utilized () No () Yes If No, explain how resident gets transportation to medical appointments. _____

Veterans Status: () No () Yes Utilizes VA outpatient programs () No () Yes Rx assistance? () No () Yes

Details: (ie: supplement info., service dates, d/c type, pension, disability, Rx co-pay, outpatient center, etc.) _____

Income/Resources and Other Information

Social Security \$ _____ month Food Stamps \$ _____ re-cert _____

SSI \$ _____ month Rent \$ _____ re-cert _____

Veterans \$ _____ month Other \$ _____

Retirement \$ _____ month Other \$ _____

Primary Care Physician _____ Phone _____ Fax _____

Address _____ Hospital _____

Other Physician _____

Pharmacy Choice _____ Phone _____

Advanced Directives () No () Yes Resident has copy () No () Yes Hospital has copy () No () Yes

Does Resident have a Power of Attorney or Legal Guardian () No () Yes _____

Burial/Funeral Arrangements (where, who, how) _____