PATIENT INTAKE FORM

Patient Name: ________________________________

Date: ______________

Address:____

____

Home #:____________________ **Cell #:** _______________________

Work #:___________________ **Email:**___________________________________

Social Security # :______________________ **DOB:**_____/______/_______

Age: ___________ **Status:** Single Married Widowed Divorced Separated

Emergency Contact Person:_____________________________________

Relationship to you:________________ **Contact #:**_________________________

Primary Care Physician:_______________________ **Telephone:**______________

How did you hear about our office?_____________________________________

Insurance Company Name:____

Policy #:___________________________ **Group #:**__________________________

INTAKE CONSENT

I ____________________________________ gives permission and authority to Home Health Care Plus to act on my behalf for personal care services in accordance with appropriate documentation, scheduling appointments, and follow-up of my pending authorization of services. Please Fax form to (215) 474-2277. For more information call (215) 474-2273.

I have read and understand the foregoing.

____

Patient's Signature **Date**

COMMUNITY CHOICE

ITEMS REQUIRING VERIFICATION FOR SERVICES

If possible, please have these things ready at the time of your interview. Documents must be Xerox for consumer choice services.

Identity/Medical Resources

___ Social Security Card

___ Medicare Card

___ Blue Cross/Blue Shield Card

___ Other Medical Insurance Card

___ Access Card

___ Age

Income (Gross Amount)

___ Social Security Statement

___ SSI Statement

___ Veteran's Benefits

___ Railroad Retirement

___ Black Lug Benefits

___ Pension _____________(specify)

___ Civil Service Annuity

___ Dividends/Interest

___ Rental Income

___ Alimony/Child Support

___ Support from Relatives

___ Other Disability Benefits

___ Unemployment Benefits

___ Other Income (specify)

Assets/Resources

___ Savings and/or Checking Account (3mos. Summery)

___ Bank Certificates

___ Bonds/Stocks

___ Christmas/Vacation Club

___ Life Insurance Policies

___ Burial Reserve Document

___ Trust Agreement

___ Cash on Hand

___ Ownership of Property (Deed)

___ Value of non-resident property

___ Settlement papers for property sold in the past 5yrs.

___ Unpaid Medical Bills of applicant in the last 3 months

PA Department of Aging Waiver Program

Physician Authorization Form

Patient Name: ___________________________________ DOB: _______________

Address:____

____

Dear Doctor:

Please be advised that the above-named consumer is applying for the Pennsylvania Department of Aging (PDA) Waiver Program, which is a care at home alternative to nursing home placement. Below is a prescription authorization for "the consumer's appropriate level of care", which must be completed by the consumer's physician prior to the start of services.

The PDA Waiver "Consumer Choice" approach is being introduced by the Pennsylvania Department of Aging and Department of Public Welfare to ensure that person who are eligible for nursing facility are offered a choice of home and community based services.

I certify that the above named person requires the support provided through Home and Community-Based Services or a Nursing Facility ______ Yes _____ No

Check appropriate length of care required.

Long-term (Over 180days)_____________ Short-term (180days or less)___________

Primary Diagnosis: ____

Please confirm by signature, the above named consumer's level of care and diagnosis. Please return form to consumer to be presented during care assessment and/or fax to attn: Case Manager 215-474-2277.

Your patient won't be able to receive services in their home until this form is received. Thank you for your prompt attention to this very important matter.

Physician Signature: ____ Date: __________________

Physician License#: ____ (Only MD or DO accepted per Pennsylvania Regulation)