Intake Form

Information About Me		
Name		Date of Birth
Date of Intake Form		SSN
Address		City
State	Zip	Race/Ethnicity
Phone		Email

Please check all the supports you are interested in receiving. As we get to know you, we can work together to create a range of supports that are customized to your needs and interests.

☐Social Connections ☐Navigating Community Resources ☐Employment Development & Support
☐Respite (approx. # days) ☐Independent Living Skills (Specify): ☐Personal Care
☐Financial & Benefits Management ☐Participation in Activities of Interest ☐Supervision
☐ Medical ☐ Communication Support ☐ Behavioral ☐Other (Specify):

Information About the Important People in My Life

Who do you live with?	☐I live with my family. ☐I live independently.	☐I live in a provider-managed group setting. ☐Other:		
Please provide us with information about the people you live with: *If you live in a provider-managed setting, please provide the contact information for the provider.*	**Name**	**Relationship**	**Phone**	**Email**
Who can we contact if there is an Emergency?	**Name**	**Relationship**	**Phone**	**Email**
Who helps you make decisions? *Please attach legal documentation*	☐I have a power of attorney. Name/Relationship:		☐I have a guardian. Name/Relationship:	
	☐I don't have a power of attorney or a guardian.			

Information About the Important People in My Life (Page 2)

<table>
<tr><td rowspan="10">Please tell us more about your parents.</td><td>Father</td><td>Mother</td></tr>
<tr><td>Name</td><td>Name</td></tr>
<tr><td>Birthdate</td><td>Birthdate</td></tr>
<tr><td>Address (if different)</td><td>Address (if different)</td></tr>
<tr><td>Phone Number(s)</td><td>Phone Number(s)</td></tr>
<tr><td>Email</td><td>Email</td></tr>
<tr><td>Occupation</td><td>Occupation</td></tr>
<tr><td>Is your father living?
☐Living ☐Deceased, date:</td><td>Is your mother living?
☐Living ☐Deceased, date:</td></tr>
<tr><td>Marital Status</td><td>Marital Status</td></tr>
<tr><td>General Health Status
☐Excellent ☐Good ☐Fair ☐Poor</td><td>General Health Status
☐Excellent ☐Good ☐Fair ☐Poor</td></tr>
<tr><td>What can you tell us about the other important people in your life?</td><td colspan="2"></td></tr>
<tr><td colspan="3">Information About My Needs (Page 1)</td></tr>
<tr><td colspan="3">We ask a lot of questions about your health and wellness because we want to understand how best to serve you and help you achieve your goals. All of the information we collect is confidential and protected under federal HIPAA regulations. If you have any questions or concerns about the information we are asking for, please feel free to contact us. We would be happy to discuss it with you.</td></tr>
<tr><td>Insurance Information</td><td>☐MA#</td><td>☐Medicare# Part: ☐A ☐B ☐C</td></tr>
<tr><td rowspan="2">Other Insurance Carrier
We may request a copy of your insurance card</td><td>Name</td><td>Group#</td></tr>
<tr><td>Phone</td><td>ID#</td></tr>
<tr><td rowspan="2">Who is your primary healthcare provider?</td><td>Name</td><td>Address</td></tr>
<tr><td>Phone
Fax</td><td>Date of last appointment</td></tr>
<tr><td>What are the names of your disabilities and diagnoses?</td><td colspan="2"></td></tr>
</table>

<table>
<tr><td rowspan="3">Tell us about your history of hospitalizations.
You may attach a separate list if necessary</td><td>Date</td><td>Reason</td><td>Hospital/Physician</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="4">Information About My Needs (Page 2)</td></tr>
</table>

<table>
<tr><td>What kind of diet do you eat?</td><td colspan="4">☐Regular ☐Diabetic ☐Other (please describe):</td></tr>
<tr><td>Tell us more about your dietary needs.</td><td colspan="4">☐I am at a high risk for choking. ☐I require a pureed diet. ☐I use a tube for eating.
☐I use special utensils to help me eat. ☐I need someone to help me eat. ☐I eat independently.</td></tr>
<tr><td>Do you see a GI doctor?
☐Yes ☐No</td><td>Date of last appointment</td><td colspan="2">Physician</td><td>Phone</td></tr>
<tr><td>Is there anything else we should know about your eating habits?</td><td colspan="4"></td></tr>
<tr><td>Do you have any allergies?
☐Yes ☐No</td><td colspan="4">Please List:</td></tr>
<tr><td rowspan="4">Do you have a history of mental health treatment?
You may attach a separate list if necessary
☐Yes ☐No</td><td>Date</td><td>Treatment Center</td><td>Inpatient?</td><td>Clinician</td></tr>
<tr><td></td><td></td><td>☐Yes ☐No</td><td></td></tr>
<tr><td></td><td></td><td>☐Yes ☐No</td><td></td></tr>
<tr><td></td><td></td><td>☐Yes ☐No</td><td></td></tr>
<tr><td>Do you see a psychiatrist or psychologist?
☐Yes ☐No</td><td>Date of last appointment</td><td colspan="2">Clinician</td><td>Phone</td></tr>
<tr><td>If yes, what is your diagnosis?</td><td colspan="4"></td></tr>
<tr><th colspan="5">Information About My History</th></tr>
<tr><td rowspan="5">What school(s) did you attend?</td><td>Name & Address</td><td>Contact</td><td>Phone</td><td>Dates</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">Have you attended any other special programs or training (SYE, etc.)?
☐Yes ☐No</td><td>Name & Address</td><td>Contact</td><td>Phone</td><td>Dates</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Is there anything else you would like us to know about you?</td><td colspan="4"></td></tr>
</table>

*Please complete and return this form with the requested attachments to the PMHS representative you've been working with.