

Form Action

- Add
 Change
 Deceased

State of Alabama
Department of Senior Services
ElderConnect Alabama
Client Intake Form

Worker's Initials**Date**

Basic Client Information		This section applies to all clients and Alabama Cares care recipients.			
Last Name:		First Name:		Middle Initial:	
Date of Birth: (mm/dd/yyyy)		Street Address:		City:	
State:	Zip:	Phone: ()	County:	SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race: (Check Only One)		Program: (Check Only One)		Type of Case: (Check Only One)	
<input type="checkbox"/> African-American <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic		<input type="checkbox"/> Alabama Cares <input type="checkbox"/> Caregiver I&R/A <input type="checkbox"/> E&D Waiver <input type="checkbox"/> Regular I&R/A <input type="checkbox"/> SenioRx		<input type="checkbox"/> Senior Aide <input type="checkbox"/> Senior Legal Services <input type="checkbox"/> SHIP <input type="checkbox"/> Specialty Care ALF Waiver	
Source of Call: (Check Only One)					
<input type="checkbox"/> AoA/SUA <input type="checkbox"/> AoA/White House <input type="checkbox"/> Brochure <input type="checkbox"/> CMS <input type="checkbox"/> Educational session		<input type="checkbox"/> Family/friend <input type="checkbox"/> Health fair <input type="checkbox"/> Internet <input type="checkbox"/> Medicare beneficiary <input type="checkbox"/> Medicare publication		<input type="checkbox"/> Newspaper/magazine <input type="checkbox"/> Other agency <input type="checkbox"/> Professional publication <input type="checkbox"/> Professionals <input type="checkbox"/> Radio/TV	
Caller Information:		This section applies to all callers and Alabama Cares clients (caregivers).			
Last Name:		First Name:		Title:	
Street Address:		City:		State:	Zip:
Phone: ()	Relationship to Client:		Email Address:		
Detailed Information:					
Living Arrangement: (Check Only One)		Sources of Income: (Check All That Apply)		Monthly Income Range: (Check Only One)	Other Benefits: (Check All That Apply)

<input type="checkbox"/> Alone <input type="checkbox"/> With Spouse Only <input type="checkbox"/> With Spouse and Others <input type="checkbox"/> With Child <input type="checkbox"/> With Others <input type="checkbox"/> Group Setting with Non-relatives <input type="checkbox"/> Transient/Homeless	<input type="checkbox"/> Employee Pension <input type="checkbox"/> Employment <input type="checkbox"/> Interest <input type="checkbox"/> Investment <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Social Security <input type="checkbox"/> Social Security Disability <input type="checkbox"/> Supplemental Security Income <input type="checkbox"/> VA <input type="checkbox"/> Other: Alimony, Family Support	<input type="checkbox"/> 0 – 512 <input type="checkbox"/> 513 – 600 <input type="checkbox"/> 601 – 700 <input type="checkbox"/> 701 – 800 <input type="checkbox"/> 801 – 900 <input type="checkbox"/> 901 – 1,000 <input type="checkbox"/> 1,001 – 2,000 <input type="checkbox"/> 2,001 – Above	<input type="checkbox"/> Food Stamps <input type="checkbox"/> Other
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(Complete Reverse Side)

Health Conditions: *(Check All That Apply)*

<input type="checkbox"/> Alcoholism <input type="checkbox"/> ALS <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Amputee <input type="checkbox"/> Aneurysm <input type="checkbox"/> Arthritis <input type="checkbox"/> Bedridden <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Colostomy <input type="checkbox"/> COPD <input type="checkbox"/> Decubitus Ulcer <input type="checkbox"/> Dementia (Diagnosed) <input type="checkbox"/> Dementia (Undiagnosed) <input type="checkbox"/> Diabetes <input type="checkbox"/> Disability	<input type="checkbox"/> Epilepsy <input type="checkbox"/> Eye Disease <input type="checkbox"/> Falls <input type="checkbox"/> Fractured Hip <input type="checkbox"/> Head Injury <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Heart Disease/Condition <input type="checkbox"/> Heat Exhaustion <input type="checkbox"/> Hypertension	<input type="checkbox"/> Immune System Disorder <input type="checkbox"/> Impaired Mobility <input type="checkbox"/> Incontinence (Bladder) <input type="checkbox"/> Incontinence (Bowel) <input type="checkbox"/> Kidney Disease/Condition <input type="checkbox"/> Liver Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other Fracture <input type="checkbox"/> Paralysis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Stroke <input type="checkbox"/> Terminally Ill <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Other
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Health Care Coverage: <i>(Check All That Apply)</i>	Language: <i>(Check Only One)</i>	Follow-up Required: <i>(Check All That Apply)</i>
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<input type="checkbox"/> Group Health Plan <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid HMO <input type="checkbox"/> Medicare Disability <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Medicare Medigap/Supplemental <input type="checkbox"/> Medicare Part A <input type="checkbox"/> Medicare Part B <input type="checkbox"/> Medicare PPO <input type="checkbox"/> No Health Care Coverage <input type="checkbox"/> Prescription Plan <input type="checkbox"/> Veterans Benefits <input type="checkbox"/> Other: Private Pay	<input type="checkbox"/> English <input type="checkbox"/> American Sign Language <input type="checkbox"/> Chinese <input type="checkbox"/> Farsi <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Hindi <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Russian <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> African Languages <input type="checkbox"/> Other	<input type="checkbox"/> Contacted Referral Source <input type="checkbox"/> Deceased <input type="checkbox"/> No Further Need <input type="checkbox"/> No Resolution – No Service <input type="checkbox"/> No Resolution – Out of Service Area <input type="checkbox"/> Not Receiving Service – Did Not Pursue <input type="checkbox"/> Not Receiving Service – Eligibility Issues <input type="checkbox"/> Not Receiving Service – Financial Limitation <input type="checkbox"/> Not Receiving Service – Lack of Transportation <input type="checkbox"/> Not Receiving Service – Refused <input type="checkbox"/> Received Information <input type="checkbox"/> Receiving Service <input type="checkbox"/> Situation Changed <input type="checkbox"/> Not Receiving Service – On Waiting List
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Follow-up Required: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", by what date? (mm/dd/yyyy) _____	Assets/Resources: <i>(Estimate client's total assets)</i> _____
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Counselor Information:

Date of Contact: (mm/dd/yyyy)	Counselor's Initials:	Time Spent on this Request:
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Activity/Type of Request: <i>(Check Only One)</i>		Information Provided: <i>(Check All That Apply)</i>	
<input type="checkbox"/> Telephone Call <input type="checkbox"/> Face-to-Face Interview <input type="checkbox"/> Fax <input type="checkbox"/> E-mail	<input type="checkbox"/> Letter <input type="checkbox"/> Other Correspondence <input type="checkbox"/> Staff Consultation <input type="checkbox"/> Other	<input type="checkbox"/> ADC Listing <input type="checkbox"/> ADC Tip Sheet <input type="checkbox"/> Alabama Shopper's Guide <input type="checkbox"/> ALF Listing <input type="checkbox"/> ALF Tip Sheet <input type="checkbox"/> Health Insurance Guide <input type="checkbox"/> Housing Report	<input type="checkbox"/> LTC Shopper's Guide <input type="checkbox"/> Medicare Handbook <input type="checkbox"/> Medicare Supplemental Guide <input type="checkbox"/> Nursing Home Q&A Packet <input type="checkbox"/> Nursing Home Report <input type="checkbox"/> Nursing Home Tip Sheet <input type="checkbox"/> Other
Comments:			