OPTIMUM HEALTHCARE SERVICES LLC

**SERVICE INTAKE(REFERRAL) FORM**

Date of Application:

Applicant name:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Date of Birth:

Social Security Number: \_\_\_\_\_\_ Medicaid Number: MCO

No. \_\_\_\_

Is applicant their own guardian? \_\_\_\_\_\_\_ If not, who is?

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Name: \_\_\_

Address: \_ \_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (home) \_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_ \_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL**

Primary Disability:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Disability: \_\_\_\_\_\_\_\_\_\_\_\_Date of Onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_

**FINANCIAL**

Current benefits (list amount received each month)

SS SSI SSDI Food Stamps

AFDC Other

Have you received past benefits that are now terminated?

**EDUCATION**

School/Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Highest Grade Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you participate in Special Education?

Educational Goals:

**VOCATIONAL**

Please list previous employers / work experiences, job duties, dates and reasons for leaving.

Employer:

Address:

Phone:

Manager/Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Employment: *(start date)* *(end date)*

Duties / Responsibilities:

Reason for Leaving:

Hourly wage: \_\_\_\_\_\_\_\_\_\_\_\_

Employer:

Address:

Phone:

Manager/Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Employment: *(start date)* *(end date)*

Duties / Responsibilities:

Reason for Leaving:

Hourly wage:

**Attach additional information, social history, medication list and care plan**

Please identify vocational interests, as well as your specific strengths, and any other information that would be helpful for us to know:

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATED SKILLS**

Self help skills you are able to perform: \_\_\_\_\_\_\_\_\_

Strengths:

Areas of Need:

|  |  |
| --- | --- |
| Leisure time preferences: |  |
| **REFERRAL**  Referral Source: |  |
| Address: | Zip: \_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Applicant: \_\_\_\_\_\_\_\_\_  Case Manager: \_\_\_\_\_\_\_\_ | |

Funding Source for SCL: \_\_\_\_\_\_\_\_

County of Legal Settlement:

Agencies / Individuals to receive reports:

Other interested parties you want involved on your team:

Person filling out form:

\_\_\_\_\_\_\_

OPTIMUM HEALTHCARE requires that the individual has knowledge of and support for this referral before it will be considered by the Admissions Committee. If in agreement, please sign below:

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_