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