Take Me Home, West Virginia Intake Form Version 5.2

1. Last Name	First Name	Middle Name	2. Date of Birth	3. Phone Number	
1. Gender:	5. Social Security No.	6. Medicaid No.	7.90	Consecutive Day Start Date	
M F					
8.90 Consecutive Day St	art Date - Location	9. Marital Status:	10. Ta	rget Population	
		Single		Elderly	
		Married	PI	nysical Disability	
		Divorced	M	ental Illness	
		Separated			
		Widowed			
		Other			
Question #1-10 Notes					

11. Where were you living before you moved here?	11a. Did you live with others? 🛛 Yes 🗌 No
Address	11b. If so, whom?
11c. Did you receive assistance in your home? Yes No	
11d. If so, what type of support?	
Regular help family and friends	
Aged & Disabled Waiver	
🗌 Traumatic Brain Injury Waiver	
Personal Care Program	
Home Health	
Self or private pay services	
Other assistance	
If other, please specify	

Last Name	First Name	Medicaid No.		
<u> </u>	·			
12. Do you have housing to	o which you can return?	Yes No		
12a. If yes, Address				
12b. Type of residence				
Home Owned by Participa	ant - 01			
Home Owned by Family N				
	ticipant, NOT assisted living- 03	3		
	ticipant, assisted living - 04			
Group home of no more t				
12c. Would you live with ot	thers? 🗌 Yes 🗌 No			
If yes, with whom?			7	
12d. Would you need mod	ifications and/or accommod	lations to the home to meet your c	current needs? Yes	🗌 No
12 - If an unbet?				
12e. If so, what?				
13. If you don't have housir	ng to return to, what type of	f housing would you like to find?		
Home Owned by Participa	ant - 01			
Home Owned by Family N	Vember - 02			
Apartment Leased by Part	ticipant, NOT assisted			
 living- 03 Apartment Leased by Part 	ticipant, assisted living - 04			
Group home of no more t	than 4 people - 05			
🗌 Not applicable				
13a. In what location?				
13b. Living with whom?				
Question #11-13 Notes				

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Last Name	First Name	Medicaid No.			PAGE 3
SECTION C. INCOME A	ND INSURANCE				
14. Do you have Medicaid	Yes 🗌 No				
15. Do you have Medicare	Yes 🗌 No				
16. Are you a Veteran?	🗌 Yes 🗌 No				
16a. If so have you applied	for Veteran's benefits?] Yes 🗌 No			
17. Do you have long-term	care insurance or some ot	ther type of health insura	ance? 🗌 Yes 📋	No	
17a. If yes, please explain					
18. What type and amount	of income do you receive	on a regular basis (Pleas	e round to the neares	t dollar amount)?	
All jobs (including self-employment) before taxes and deductions \$		Worker's Compensation \$			
Social Security Retirement		Unemployment Benefits \$			
Survivors of Disability Income (RSDA) \$		Dividends & Interest \$			
Supplemental Security Income		Child Support \$			

Retirement \$	
	Other \$

Alimony \$

(SSI) \$

Pensions or

19. Do you own a home with more than \$536,000 in equity? 🗌 Yes

🗌 No

Last Name First Name	Medicaid No.		PAGE 4
SECTION D. FAMILY, FRIENDS AND REPRESE	ENTATIVES		
20. Do you have a legal representative?]Yes 🗌 No		
20a. If yes (Check ALL that apply):			
🗌 Guardian 📄 Co-Guardian	Conservator	Health Care Surrogate	РОА МРОА
20b. Legal Representative Full Name	20c. Legal Rep Day Phone	20d. Legal Representative E-Mail	20e. Relationship
20f. If you have a legal representative, have	e you spoken to him /her al	bout your interest in moving to th	ne community? 🗌 Yes 🗌 No
If so, have they been supportive or unsupportive of a move? Please explain.			
21. Have you spoken to family and friends a 22. Do you have family or friends that you v 22a. If yes, who?			5 🗌 No
Name	Relationship	Phone #	Do they live locally?
Name	Relationship	Phone #	Do they live locally?
Questions #20-22 Notes			

SECTION E. FACILITY INFORMATION 23. Facility Name 23a. Facility Address 23b. Facility City 23. Facility Councy 22d. Facility Zip Code 23e. Facility Phone 22f. Facility Fax 23g. Date of Facility Address 24. Facility Councy 22d. Facility Zip Code 23e. Facility Contact Person and Title 23e. Facility Contact Person Email Address 23e. The Council of the State of Facility Address 24. Facility Contact Person and Title 24a. Facility Contact Person Email Address 25. Type of Outlifted Institution: 25. Date of Intake 27. Name of Transition Navigator Completing Intake 28. Agency Completing Intake 25. Date of Intake 27. Name of Transition Navigator Completing Intake 28. Agency Completing Intake 25. Date of Intake 27. Name of Transition Navigator Completing Intake 28. Date referral received from ADRC 25. Date of Intake 27. Referral Source: 30. Date referral received from ADRC 26. Date of Intake 28. Control of the Section O ADRC - Non Section O Section C O Designee Note: 29. Referral Source: 30. Date referral received from ADRC 30. Date referral received from ADRC 29. The Individual reside in a qualified institution for at least 90 days? Yes No 3. Is the individual creside in a qualified institutio	Last Name	First Name	Medicaid No.		PAGE 5
23. Facility Name 23a. Facility Address 23b. Facility City 23c. Facility County 23d. Facility Zip Code 23e. Facility Phone 23f. Facility Fax 23g. Date of Facility Admission 23c. Facility County 23d. Facility Zip Code 23e. Facility Phone 23f. Facility Fax 23g. Date of Facility Admission 24. Facility Contact Person and Title 24a. Facility Contact Person E-mail Address Nursing Facility- OI IND - 03 25. Type of Qualified Institution 24a. Facility Contact Person E-mail Address Nursing Facility- OI IND - 03 25. Date of Intake 27. Name of Transition Navigator Completing Intake 28. Agency Completing Intake 28. Agency Completing Intake 29. Referral Source: ADRC - Section Q ADRC - Non Section Q Solf Family or Friend LTC Ombudsman 29. Legal Aid Advocate Care Coordinator Community Provider Otherstead CIL Facility 20. Other (please describe) Describe 'Other' Referral Source: 30. Date referral received from ADRC 20. Tool of the individual reside in a qualified institution? Yes No 3. Is the individual reside in a qualified institution? Yes No 3. Is the individual reside in a qualified institution for at least 90 days? <td< td=""><td></td><td></td><td></td><td></td><td></td></td<>					
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