CHESAPEAKE HEALTH DEPARTMENT SCREENING INTAKE/REFERRAL FORM

****PLEASE COMPLETE AS MUCH AS POSSIBLE --- FAX TO ATTN: PRE-ADMISSION SCREENING/FAX NUMBER: 757-382-8725****

CLIENT INFORMATION

NAME: _____ DOB: _____ CLIENT SSN: _____

SEX: ☐M ☐F PHONE NUMBER: _____ ☐HOME ☐WORK ☐CELL (OK TO TEXT? ☐YES ☐NO)

ADDRESS: _____

WHAT IS CLIENT'S CURRENT DIAGNOSIS? _____

WHAT ARE CLIENT'S CURRENT NEEDS (bathing, fall risk, not able to walk, etc)?

_____

WHAT SERVICES ARE BEING REQUESTED?

☐PERSONAL CARE/EDCD WAIVER (☐TECH WAIVER) ☐NURSING HOME ☐PACE ADULT DAY CARE

CLIENT'S CONTACT PERSON INFORMATION

NAME: _____

PHONE NUMBER: _____ ☐HOME ☐WORK ☐CELL (OK TO TEXT? ☐YES ☐NO)

RELATIONSHIP TO CLIENT: _____ ☐GUARDIAN ☐PAYEE ☐POA

OTHER INFORMATION

DO THEY HAVE A PENDING MEDICAID APPLICATION? ☐YES ☐NO ☐CURRENTLY RECEIVING ☐CHKD EPAS PORTAL

WHAT IS THEIR MEDICAID NUMBER/CASE NUMBER? _____

HAVE THEY BEEN HOSPITALIZED IN THE LAST 12 MONTHS? ☐YES ☐NO

WHEN? _____ WHERE? _____

HAVE THEY BEEN SCREENED BEFORE? ☐YES ☐NO ☐CHECKED EPAS PORTAL

WHEN? _____ WHERE? _____

REFERRAL SOURCE

REFERRING AGENCY: _____ DATE: _____

NAME: _____ PHONE NUMBER: _____

RELATIONSHIP TO CLIENT: _____

INTERNAL USE ONLY		
Receiving Clerk	Call In Date (Initials/Date): _____	
WebVision	Client ID #: _____	
Scheduling Clerk	Referral Date: _____	Appt. Date/Time: _____