INTAKE CHECKLIST

NAME: _____ MEDICAID#: _____

CONGREGATE RESIDENTIAL: _____ SPONSORED: _____

ADMISSION DATE: _____

Initial and Date as Received/Distributed

DOCUMENT	RECEIVED	DISTRIBUTED	N/A	INITIALS	DATE	COMMENT
Application for Services						
Rights/ Information Release (s)						
Program Rules						
Rules of Conduct						
Fall Risk						
Admission MAR						
30 Day Meds or Scripts						
OTC Med Authorization						
TB Test (within 30 days)						
Physical (within 1 year)						
Insurance Cards/Copy						
Advance Medical Directive (Y/N)						
SIS						
60 Day Assessment Sheets						
Payee Information						
Guardianship Documentation						
Authorized Rep Documentation						
ID Card/Copy						
Psychological Eval w/ID DX						
Capacity to Consent						
Personal Items						
LOF						
DMAS 225						
PCP Parts I - IV						
Other						

****Bold Items Come From Support Coordinator****