Intake Form

Covering Hands
Home Care, LLC
2323 South 109th St Suite
200A, West Allis, WI 53227
O) 414 249 4152
F) 414 252-0018

☐ Private Pay ☐ 3rd Party Payer ☐ Other	☐ New Admit ☐ Other	Referral Source_____ Ref Phone: _____ Referral Date_____ SOC_____ Info taken by_____

Client Info

Name *(Last, First):* MRN:_____
_____
DOB_____ SSN: _____
Age_____ Sex: _____Lives With: _____
Primary Language: _____
Address: _____ City: _____
State: _____Zip: _____ Phone: _____
Emergency Contact:
Name: _____Relationship: _____
Address: _____ City: _____
State: _____Zip: _____ Phone: _____

Billing

☐3rd Party Payer # Effective Dates	Subscriber:
☐ Private Pay	Admit: _____Reject: _____ Reason

History/Agency

Previous/Current Agency: _____Phone: _____
Past surgery(s): _____
Allergies: _____
Diagnosis:

Services Requested

☐ PCW
☐ HMKR
☐ COMPANION
☐ Other
Referred by
_____

Services Requested (Specify discipline, frequency/duration)

☐ Dressing	☐ Skin Care	☐ Transfers
☐ Meals	☐ Splint/Braces	☐ Positioning
☐ Oral	☐ Hygiene	☐ Bathing
☐ Shaving	☐ Hair Care	☐ Mobility
☐ Bathroom Assistance	☐ Laundry	☐ Other
☐ Light House Keeping	☐ Nail Care	

☐ Walker
☐ Wheelchair
☐ Cane
☐ Crutches

ADL's
☐ Independent
☐ Dependent

Medical

Primary care Physician
Name: _____Phone: _____ Fax: _____
Address: _____City: _____State: _____ ZIP:
Pharmacy name: _____

Misc.

Mental: _____
Diet: _____
Hearing/Vision/Speech: _____

Below this for Office use only

Client or Client's representative Name/Signature

Name: _____Signature: _____Date: _____
Covering Hands Home Care Representative Name/Signature
Name: _____Signature: _____Date: _____
PCW/HMKR/Companion: _____ Phone: _____ EMP ID:
Address: _____ City: _____ State: WI Zip Coode: _____