UBUNTU CARE
WE CARE ABOUT THE HUMAN WELL BEING

INTAKE FORM

MEMBER INFORMATION	
Date:	**Staff Taking Intake:**
Member Name:	**SSN:**
DOB:	**Gender:**
Marital Status:	
Address:	
City:	**Zip:**
Telephone:	**Other #:**
Placement:Other	
If Other:	
Language Spoken:	
INSURANCE INFORMATION	
Primary Ins:	**Policy #:**
Secondary Ins:	**Policy #:**
DIAGNOSIS:	**CODES:**

MEDICATIONS: (you may attach list on a separate Sheet)	
CAREGIVER NAME:	**Relationship:**
Address:	
City:	**Zip:**
Telephone:	**Other #:**
REFERRAL SOURCE:	**Phone**:
Relationship:	
Previously had services? **Yes** **No**	
Currently has services? **Yes** **No**	
If yes, is this a transfer? **Yes** **No**	
Guardian (if applies):	**Phone:**
PHYSICIAN NAME:	**Phone:**
Most recent physical/MD visit?	
Recent hospitalizations/Nursing Home/Rehab?	
COMMENTS:	