Mobility Ohio
Intake Form

Intake Date: _____

Referring Agency and Phone Number: _____

Name: _____ Phone Number: _____

Address: _____ City and Zip: _____

County: Coshocton Guernsey Muskingum Tuscarawas Other: _____

Date of Birth: _____ Social Security Number: _____ Insurance: _____

Mobility Type: Ambulatory Cane Walker Wheelchair Electric WC Scooter Can-Transfer Cant-Transfer other: _____

Please check all of the areas in which the participant may need assistance with:

- ○ Insurance/Medicaid App
- ○ Housing
- ○ Food
- ○ Clothing
- ○ Utilities
- ○ Medication/Pharmacy
- ○ Emergency Assistance
- ○ Emergency Room (non-emergency)
- ○ Transportation
- ○ Pregnancy Assistance
- ○ Dental
- ○ Behavioral Health
- ○ Legal
- ○ Adult Education
- ○ Work
- ○ Domestic Violence
- ○ Addiction Recovery

If transportation is not needed, there were referral services made: Yes No Provider: _____

Trip Information:

Destination Name: _____

Address: _____ City and Zip: _____

Appointment Date: _____ Appointment Time: _____

One way Round Trip Escort Needed: Yes No Account Type: _____

Follow Up Needed (explain): Yes No

_____

_____

_____

Entered in CTS: Yes No

Referrals made to:

_____

_____

Intake worker: _____ Supervisor: _____