Hands That Help Personal Care Agency, LLC Intake Form

DATE: _____

Client Information		
Client Name:	Gender: M / F	DOB: / /
Social Security#	Current Agency Name:	
Is client a Minor? Yes/no	Responsible Party Name:	
Parent/Guardian/POA (circle one)		
Client Address:	City: State:	Zip:
Clients Home Phone:	Mobile:	
Client Diagnosis:		
What type of insurance do you have? None/Self pay Medicare Medicaid/T19 HMO:_____ Private		
Insurance Type:	Insurance ID#:	
Insurance verified on Forward Health Portal? Yes/No (attach verification copy)		
Primary Physician Information		
Doctors Name:		
Address:	Zip:	
Phone Number:	Fax Number:	
Other Doctor info(if needed):pain management, PT/OT, Cardiologist, Pulmonary, Etc.		
Doctor Name:		
Address:	Zip:	
Phone Number:	Fax Number:	
Do you have a case manager: yes/no if yes: Name: _____		
Phone Number: _____ Fax Number: _____		
Verify MD's NPI Number (attach verification copy)		
Personal Care Worker Information		
PCW Name:	PCW Phone Number:	
PCW Address:	Zip:	
How did you hear about our Services?	**Friend Flyer Internet Radio Other**	

Hands That Help Personal Care Agency

Face to Face Referral Order

Patients Name: _____ **Date of Birth:** _____

Phone Number: _____

For Physician Use Only

Physician Name: _____

Office: _____ **Fax:** _____

Evaluation for Personal Care and/or Supportive Home Care Services.

Please Include: LIST OF DIAGNOSES

_____

_____

_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

NPI Number: _____

Please FAX completed form to #: 414-755-7688

6619 W Capitol Drive Milwaukee, WI 53216 414-763-5020 Office 414-755-7688 Fax Handsthathelppca@yahoo.com

Authorization to Release Medical Records:

Patient Information:

Name (print: DOB SSN

_____ _____ _____

Information to Be Released From:

Name of facility or provider

_____

Address City State Zip

_____ _____ _____ _____

Information to be Released: (check one)

___ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)

___ All Medical Records

___ Specific Information (Please specify):

Purpose for which the disclosure is being made: (please check one)

____ Attorney ____ Insurance _____ Doctor _____ Personal

Patient Authorization:

I Understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Exclude the following information from the records released (please initial)

_____ Drug/Alcohol abuse/treatment/diagnosis _____ Sexually transmitted diseases

_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer protected under Privacy laws.

Signature: _____ Date: _____

(Patient, guardian*, or authorized representative*)

This authorization will expire 365 days from the date signed
Possible copying fee required

Hands That Help Personal Care Agency, LLC

Authorization to Release Medical Records

I (Client/Guardian/POA Name) _____ DOB: _____

Authorize: _____
to release my medical records to:

Hands That Help Personal Care Agency, LLC
6619 W Capitol Drive
Milwaukee, WI 53216
(P) 414-763-5020 (F)414-755-7688

Information to be released:

☐ Last Three MD Visit notes

☐ Physical Assessment

☐ Medication List

☐ Mental Health Record

Client/Guardian/POA Signature: _____

Date: _____

Hands That Help Personal Care Agency, LLC

Authorization to Release Personal Care Screening Tool

I (Client/Guardian/POA Name): _____

DOB: _____

Authorize (Agency Name) _____ to release my PCST to:

Hands That Help Personal Care Agency, LLC

Client/Guardian/POA Signature: _____

Date: _____

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