

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: _____				
Personal Care Worker Information				
PCW Name:		PCW Phone Number:		
PCW Address:			Zip:	
How did you hear about our Services?	Friend	Flyer	Internet	Radio Other

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 be protected under Privacy laws.

Signature: _____ Date: _____

(Patient, guardian*, or authorized representative*)

This authorization will expire 90 days from the date signed
Possible copying fee required



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: _____