DMCPS Referral for Adult LTC (Part II – Customer Information)

Customer: **Last Name:** _____ **First Name**: _____

DOB: _____ **Home Phone**: _____ **Cell Phone:** _____

Customer Social Security #:_____ Gender: ☐M ☐F ☐**PD** ☐**DD** ☐**MI**

Address: _____ Apt#:____ City: _____ Zip Code: _____

Who does Customer live With: ☐Self ☐Relative ☐Agency ☐ Other_____

Emergency Contact: _____ **Relation**_____

Emergency Contact Telephone: _____

Guardian: ☐Yes ☐ No Name: _____ Phone: _____

Rep. Payee: ☐Yes ☐ No Name: _____ Phone: _____

POA Durable/Financial Activated: ☐Yes ☐ No Name: _____ Phone: _____

POA HealthCare Activated: ☐Yes ☐ No Name: _____ Phone: _____

FINANCIAL: Receives SSI Amount: _____ Requesting SSIE Supplement: ☐Yes ☐No

Receives SSDI Amount: _____ Other Sources of Income/Amount: _____

Primary Care Physician Name: _____ Phone: _____

Additional Medical Providers:

Type: _____ Name: _____Phone: _____

Type: _____ Name: _____ Phone: _____

Health Insurance: ☐T19 ☐Medicare ☐ Other_____

Disability Diagnosis/Health Concerns - Please Circle or Specify as Needed

Arthritis Asthma AODA Autism Brain Injury CHF COPD Dementia Depression Diabetes

Epilepsy Fibromyalgia Hearing Impairment Heart Disease HIV/AIDS Hypertension

Intellectual Disability _____ Kidney Disease/Failure Learning Disability Multiple Sclerosis

Neuropathy Paraplegia Quadriplegia Speech Impairment Vascular Disease Visual Impairment

Back Injuries: _____

Cancer:_____ Infectious Disease:_____

Mental Illness: _____ Major Surgery:_____

OTHER:

EQUIPENT **USED** IN THE HOME**:**

☐Cane ☐ Quad Cane ☐Walker ☐Seated Walker ☐Wheelchair ☐Scooter ☐Crutches ☐Hoyer Lift

☐Shower Bench/Chair ☐Raised Toilet Seat ☐Commode ☐ OTHER_____

Assistance needed to complete ADLs/IADLs in the home

Type of Assistance	**Independent**	**Assistance Needed**	**Describe Assistance Needed**
BATHING			
DRESSING			
MOBILITY			
TOILETING			
TRANSFERRING			
MEAL PREP.			
MEDICATION			
MONEY MANAGEMENT			
SHC TASKS (Specify)			

SERVICES NEEDED

☐ PERSONAL CARE ☐ SUPPORTIVE HOME CARE ☐ CASE MANAGEMENT ☐ RESPITE

☐TRANSPORTATION ☐ RESIDENTIAL ☐ ADAPTIVE AIDS ☐ HOME DELIVERED MEALS

☐ MEDICAL/DENTAL/MCARE ☐ REP-PAYEE/MONEY MANAGEMENT ☐ RESPITE

☐OTHER: _____

Additional Information:

COMPLETED BY: _____ **DATE:** _____