

BeechWood, Inc
Application / Intake Information

Date of Referral _____ **Intake Date** _____

Name: _____ **DOB** _____

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

E-mail: _____ **Other:** _____

Address: _____ **City:** _____ **Zip:** _____

Referring Case Manager: _____ **Phone:** _____

E-mail: _____ **Fax:** _____

Agency: _____

Community Support Plan: **YES** **REQUESTED**

MI Diagnosis: _____ **ICD-9** _____

Physical Diagnosis: _____ **ICD-9** _____

Behaviors: _____

Legal Matters: _____

Initial Goal Areas: _____

of Hours: _____

MA or MA-EPD: _____

Medical Assistance # _____ **Social Security #** _____

Medicare: **A** **B** **D**

Other Insurance Type _____ **Policy #** _____

Waiver: _____

Emergency Contact: _____ Relationship: _____

Phone # _____

Hospital of Choice: _____

Primary Care Physician/Clinic: _____ Phone: _____

Other Doctors:

	<u>Type</u>	<u>Name/Clinic</u>	<u>Phone</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Other Providers (PCA, Nursing, Homemaking, ARMHS, etc):

	<u>Type</u>	<u>Name/Company</u>	<u>Phone</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Allergies: _____

Advanced Directives: YES NO Request Information

Employment: YES NO Name of Company: _____

Wages: _____ Trust: _____

RSDI: _____ SSI _____ MSA _____ FS _____

Economic Assistance Case #: _____ Team #: _____

Rep Payee: Y N Request Information

Company Name/Number: _____

Bank Accounts: _____ Bank Name: _____