

BeechWood, Inc.
APPLICATION / INTAKE INFORMATION
Date of referral _____, Intake date _____

Name: _____ DOB _____

Telephone # _____ E-mail: _____

Address: _____ City _____ Zip _____

Referred by: _____ Tel _____

Fax: _____ E-mail: _____

Address _____

Diagnosis/Characteristics: _____ ICD-9 _____

Initial Assistance Areas _____ # of Hours/week _____

ID's Yes No _____

Medical Assistance # _____ Waiver _____

Social Security # _____ Medical A/B/D _____

Other Insurance: _____

Gap or MA paid plans _____

Prescription Drug Insurance: _____ ID# _____

Hospital: _____

Emergency contacts: _____

_____ Phone _____ Rel' ship _____

_____ Phone _____ Rel' ship _____

Primary Doctor _____ Tel _____
Address: _____

Other Doctors _____

Pharmacy: _____

Other Health Care Providers (Homemakers, PCA, etc.):

Company/ name: _____

Telephone number: _____

Type of service: _____

Allergies: _____

Medications:

Name	Dosage	Frequency	Use

Advance Directives Yes No Request
assistance

FINANCIAL

Unearned income:

RSDI _____ SSI _____ MSA _____ FS _____

Pension _____ Work Comp _____ Other _____

Economic Assistance Team # _____ Case # _____

Employment name, telephone, address

Bank info: _____ Branch _____

CONSERVATOR: _____ Phone: _____

REP PAYEE: _____ Phone: _____