# BeechWood, Inc
## ILS Application / Intake Information

**Referal Date:** **Service Initiation Date:**

**Name:** **DOB:**

**Gender:** **Phone:** **Cell Phone:**

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

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

**Referring Case Manager:** **Phone:** **Fax:**

**E-mail:** **Address:**

☐ **Responsable for self** ☐ **Under Gardianship** ☐ **Under Commitment**

**Legal Representative** **Office Number** **Cell Number**

**Address:**

**PMI or MA #:** **Primary Insurance Name:** **Insurance Number:**

**Spenddown** **Yes** ☐ **No** ☐

**Medicare:** ☐ **A** ☐ **B** ☐ **D** **Designated Provider:**

**Other Insurance Type:** **Policy #:**

**Waiver:** TBI ◉ CADI ○ AC ○ EW ○

**Authorized hours for ILS services**

**MI Diagnosis:** **ICD-10:**

**Physical Diagnosis:** **ICD-10:**

**Health Information - Medical History:**

**Special Dietary Needs:**

**Allergies:**

**Emergency Contact:** **Relationship:** **Phone:** **Fax:**

**Address:**

**Hospital of Choice:**

**Primary Care Clinic:** **Primary Doctor:** **Phone:** **Fax:**

**Address:**

**Other Doctors:**

| | | | |
|---|---|---|---|
| **Type** | **Clinic/Address** | **Phone** | **Fax:** |
| **Type** | **Clinic/Address** | **Phone** | **Fax:** |
| **Type** | **Clinic/Address** | **Phone** | **Fax:** |

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

| Type | Company/Address | Phone | Fax: |
|---|---|---|---|
| Type | Company/Address | Phone | Fax: |
| Type | Company/Address | Phone | Fax: |

**Additional Information:**

**Advanced Directives:** ☐ YES ☐ NO ☐ Request Information

**Employment:** ☐ YES ☐ NO

**Name of Company:**

**Wages:** **Trust:**

☐ RSDI ☐ SSI ☐ MSA ☐ SNAP

**Economic Assistance Case #:** **Team #:**

**Rep Payee:** ☐ Y ☐ N ☐ Request Information

**Company Name** **Contact Name:** **Phone:** **Fax:**

**Address:**

**Suggestions for what ILS can provide**

**Updated 2018**