DSHS
WASHINGTON STATE Department of Social and Health Services

Home and Community Services (HCS)

Intake and Referral

Date

Section 1. Applicant Information

1. Applicant's Name: Last, First, MI	2. Gender ☐ Male ☐ Female ☐ Other:	3. Birthdate	4. Social Security Number
5. Applicant's Home Address	City	State	Zip Code
5. Applicant's Mailing Address (if different	City	State	Zip Code
7. Applicant's Primary Phone Number ( )	8. Applicant's Email Address		
9. Authorized Representative's Name	Relationship to Applicant	Phone Number ( )	

10. Is Applicant Married? If yes, name of spouse: ☐ Yes ☐ No

11. Is Applicant Native American? If yes, tribal affiliation: ☐ Yes ☐ No

12. Deaf / Hearing Impaired? ☐ Yes ☐ No Vision Impaired? ☐ Yes ☐ No Interpreter Needed? If Yes, Language Spoken: ☐ Yes ☐ No

13. Is Applicant receiving hospice services at home? ☐ Yes ☐ No

Section 2. Applicant Current Location

1. Applicant's Location Name / Room Number ☐ In Home ☐ Hospital ☐ Homeless ☐ Nursing Facility ☐ Adult Family Home / Assisted Living

2. Location Phone Number ( )	3. Admit Date	4. Anticipated Discharge Date

Section 3. Medicaid Eligibility Information

Washington Apple Health? ☐ Yes ☐ No

ProviderOne ID Number: _____

Date Medicaid application was submitted: _____

For Nursing Facility Residents Only

1. Is the client PASRR positive? ☐ Yes ☐ No
2. Is a PASRR Level II assessment included with this referral? ☐ Yes ☐ No
3. SNF ProviderOne Number: _____

Section 4. Applicant Desired Setting and Services Information

Applicant's Desired Setting

☐ In-Home ☐ Skilled Nursing Facility ☐ Skilled Nursing Facility Conversion
☐ Assisted Living ☐ Enhanced / Adult Residential Care ☐ Adult Family Home ☐ Enhanced Services Facility

Applicant is Interested in (check all that apply):

☐ Adult Day Health ☐ Adult Day Care ☐ Support for Caregiver (MAC / TSOA)
☐ Personal Care Services ☐ Housing Assistance ☐ Other: _____

Section 5. Nursing Needs Screening (Check all that apply.)

☐ Indwelling catheter
☐ Skin Breakdown / Wound Care
☐ Tracheotomy / Ventilator
☐ Insulin Dependent Diabetes / Uncontrolled Diabetes
☐ Neurological Disorder: _____
☐ Other: _____
☐ Traumatic Brain Injury
☐ Paralysis
☐ Recent Stroke

Personal Care Needs (Check all that apply.)

☐ Toileting ☐ Personal Hygiene
☐ Bathing ☐ Turning / Repositioning
☐ Mobility ☐ Medication Assistance
☐ Cognitive / Memory Impairments

Section 6. Referent Information

1. Full Name of Agency or Facility	2. Type of Facility
3. Referent's Name	4. Referent's Role / Relationship to Applicant
5. Phone Number ( ) Ext.	

Intake and Referral form for Social Services.
Barcode 10570 DSHS form 10-570

Purpose: Communication to social services intake regarding an individual requesting a functional assessment for long-term services and supports (LTSS). Initial eligibility for LTSS is done concurrently by both the financial worker and the social worker / case manager.

Instructions

- Please type or print clearly and fill out as completely as you can to assist in processing the request for service.
- Fax form to Home and Community Services: 855-635-8305.
- If you have questions about submitting the form please contact Statewide Eligibility & Service Delivery (SESD) Toll-free: 877-429-7019.

Section 1. Application Information

(1-13) Enter all known applicant information. Include all identifying information.

13. Enter "Yes" or "No" to whether the applicant is receiving hospice services while residing in their home / community-based setting. Excludes hospice inpatient and facility / residential type admit settings.

Section 2. Applicant Current Information

a. Enter the applicant's current location and check the box that best applies to the applicant's current setting.

b. Admit date: If applicable, enter the date the applicant admitted to the facility they currently reside.

c. Anticipated discharge date: If applicable, enter the anticipated discharge date for their current facility.

Section 3. Medicaid Eligibility Information

a. Enter "Yes" or "No" to whether the client is on Washington Apple Health. Washington Apple Health is the WA Medicaid programs.

b. Enter the client's ProviderOne number, if known. It can be found on the applicant's services card.

c. If the applicant does not currently receive WA Apple Health benefits, an application is necessary to apply for Long Term Services and Supports. Please indicate the date the application was submitted.

d. PASRR information box should be completed only if the applicant is a current resident of a nursing facility. Check "Yes" if the applicant required and/or received a PASRR Level II assessment.

Section 4. Applicant Desired Setting and Services Information

a. If the applicant's desired setting is known, check the box(es) that applies.

b. If the applicant is requesting specific services that are listed, check the box(es) that applies.

Section 5. Nursing Needs Screening and Personal Care Needs

Please check all boxes that apply to the applicant.

Section 6. Referent Information

Include as much information as is known. Include the referent's role or relation to the applicant, if applicable.