



Intake and Referral

DATE

Section 1. Applicant Information

1. APPLICANT'S NAME: LAST, FIRST, MI		2. GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		3. BIRTHDATE		4. SOCIAL SECURITY NUMBER	
5. APPLICANT'S HOME ADDRESS				CITY		STATE	
6. APPLICANT'S MAILING ADDRESS (IF DIFFERENT)				CITY		STATE	
7. APPLICANT'S PRIMARY PHONE NUMBER ()				8. APPLICANT'S EMAIL ADDRESS			
9. AUTHORIZED REPRESENTATIVE'S NAME				RELATIONSHIP TO APPLICANT		TELEPHONE NUMBER: ()	
10. IS APPLICANT MARRIED? IF YES, NAME OF SPOUSE: <input type="checkbox"/> Yes <input type="checkbox"/> No				11. IS APPLICANT NATIVE AMERICAN? IF YES, AFFILIATION: <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. DEAF / HEARING IMPAIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No		VISION IMPAIRED? <input type="checkbox"/> Yes <input type="checkbox"/> No		INTERPRETER NEEDED? IF YES, LANGUAGE SPOKEN: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Section 2. Applicant Current Location

1. APPLICANT'S LOCATION NAME / ROOM NUMBER			<input type="checkbox"/> In Home	<input type="checkbox"/> Hospital	<input type="checkbox"/> Homeless
			<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Adult Family Home / Assisted Living	
2. LOCATION PHONE NUMBER ()			3. ADMIT DATE		4. ANTICIPATED DISCHARGE DATE

Section 3. Medicaid Eligibility Information

Washington Apple Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	FOR NURSING HOME RESIDENTS ONLY
ProviderOne ID Number: _____	1. Is the client PASRR positive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Medicaid application was submitted: _____	2. Is a PASRR Level II assessment included with this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. NF 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:

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.)

<input type="checkbox"/> Indwelling catheter	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Toileting	<input type="checkbox"/> Personal Hygiene
<input type="checkbox"/> Skin Breakdown / Wound Care	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Bathing	<input type="checkbox"/> Turning / Repositioning
<input type="checkbox"/> Tracheotomy / Ventilator	<input type="checkbox"/> Recent Stroke	<input type="checkbox"/> Mobility	<input type="checkbox"/> Medication Assistance
<input type="checkbox"/> Insulin Dependent Diabetes / Uncontrolled Diabetes		<input type="checkbox"/> Cognitive / Memory Impairments	
<input type="checkbox"/> Neurological Disorder: _____			
<input type="checkbox"/> Other: _____			

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 the Home and Community Services office in your region for intake.
- If you have questions about submitting the form please contact your regional office at the number below.

REGION 1 – Pend Oreille, Stevens, Ferry Okanagan, Chelan, Douglas, Grant, Lincoln, Spokane, Adams, Whitman, Klickitat, Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield and Asotin: 509-568-3767 or 1-866-323-9409; **fax 509-568-3772**

REGION 2N – Snohomish, Whatcom, Skagit, Island, and San Juan 800-780-7094; **fax 425-339-4859**;
Nursing Facility Intake, **fax 425-977-6579**

REGION 2S – King: 206-341-7750; **fax 206-373-6855**

REGION 3 – Pierce, Kitsap, Thurston, Mason, Lewis, Grays Harbor, Pacific, Cowlitz, Clark, Clallam, Jefferson, Skamania and Wahkiakum: 800-786-3799; **fax 1-855-635-8305**

Section 1. (1-12) Enter all known applicant information. Include all identifying information.

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 from the facility they currently reside.

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 program.
- b. If known, enter the client's ProviderOne number. 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.