|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | HOME AND COMMUNITY SERVICES  **Intake and Referral** | | | | | | | | | | |  |
| DATE |
| **Section 1. Applicant Information** | | | | | | | | | | | | |
| 1. APPLICANT’S NAME: LAST, FIRST, MI | | | 2. GENDER  Male  Female | | | | | | 3. BIRTH DATE | | | 4. SOCIAL SECURITY NUMBER |
| 5. APPLICANT’S HOME ADDRESS CITY STATE ZIP CODE | | | | | | | | | | | | |
| 6. 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 TELEPHONE NUMBER:  **(     )** | | | | | | | | | | | | |
| 10. IS APPLICANT MARRIED? IF YES, NAME OF SPOUSE:  Yes  No | | | | | | | | 11. IS APPLICANT NATIVE AMERICAN? IF YES, 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 HOME RESIDENTS ONLY   1. Is the client PASRR positive?  Yes  No 2. Is a PASRR Level II assessment included with this referral?  Yes  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.)** | | | | | | | | | | **Personal Care Needs (Check all that apply.)** | | |
| Indwelling catheter  Traumatic Brain Injury  Skin Breakdown / Wound Care  Paralysis  Tracheotomy / Ventilator  Recent Stroke  Insulin Dependent Diabetes / Uncontrolled Diabetes  Neurological Disorder:  Other: | | | | | | | | | | 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 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.** (1-13) 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**

1. Enter the applicant’s current location and check the box that best applies to the applicant’s current setting.
2. Admit date: If applicable, enter the date the applicant admitted to the facility they currently reside.
3. Anticipated discharge date: If applicable, enter the anticipated discharge date from the facility they currently reside.

**Section 3. Medicaid Eligibility Information**

1. Enter “Yes” or “No” to whether the client is on Washington Apple Health. Washington Apple Health is the WA Medicaid program.
2. If known, enter the client’s ProviderOne number. It can be found on the applicant’s services card.
3. 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.
4. 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**

1. If the applicant’s desired setting is known, check the box(es) that applies.
2. 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.