Abundant Life Inc.

Innovations Waiver I/DD Day Program

Intake Information

Name of Referring Individual: _____

_____ **Self** _____ **Guardian** _____ **Agency** _____ **Medical Professional**

Contact Information for Referring Individual:

Address: _____

Telephone: _____

Client Information: ***(☐ Same as Above)***

Name: _____

Address: _____

Telephone: _____

Birthdate: _____ Social Security Number: _____

Medicaid #: _____

***** Does the client have a current authorization for Innovations Waiver service?*** Yes _____ No _____

***** Has the client ever participated in an Innovations Waiver Day Program service before?*** Yes _____ No _____

If yes, when and how long was he/she in the service and was the service terminated? _____

_____

Guardian Contact Information: **(☐ *N/A*)**_____

_____

Admitting Primary Diagnosis: _____

_____

Medications: _____

_____

Presenting Problem(s): _____

_____

Needs: _____

_____

Strengths: _____

_____

Other Services Currently Receiving: (***Name, Address & Phone Number***):

Medical Doctor: _____

Therapist: _____

Psychiatrist: _____

Care Coordinator (***Please provide copy of ISP***):_____

Allergies: _____

Other: _____

****

Behavior Concerns:_____

_____

_____

Safety Concerns: _____

_____

_____ _____

Signature of Referral Source ***Date***