CARING HEARTS HOME HEALTH SERVICES, INC.
5969 E. LIVINGSTON AVE. SUITE 110
COLUMBUS, OH 43232
614-863-6950 – PHONE
614-863-6957 - FAX

Intake Form

Intake Date: _____ **Intake Source:** _____ **Phone #:** _____

Client Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex: M/F**

Marital Status: S M W D Sep **Language Spoken:** _____

Address: _____
Street City State Zip County

Phone Numbers: _____
What medical conditions require your need for HH services? _____
Most recent hospitalization: Where? When? _____
Most recent nursing home stay: Where? When? _____
Have you received services from a HH agency in the past? Y/N If yes, when: _____
Primary care physician: _____ **Phone #:** _____
Office location: _____

Do you live alone? **Yes / No**
Lives with: _____ **Relationship:** _____
Home Phone#: _____ **Cell Phone#:** _____ **Work Phone#:** _____
Emergency Contact:
Name: _____ **Relationship:** _____
Home Phone#: _____ **Cell Phone#:** _____ **Work Phone#:** _____

Intake Received By: _____ **Date:** _____

BILLING INFORMATION

Social Security #: _____

Medicare: Number: _____ **Category:** **Part A** **Part B** **Part D** **Humana** **Anthem**

Insurance Verified By: _____ **Date:** _____

Medicaid: Case #: _____ **Medicaid Number:** _____

Caresource **PASSPORT** **CareStar Waiver** **Molina**
All Service Plan: _____ **Case Manager:** _____ **Phone#:** _____
(Date ASP Requested)

Insurance Verified By: _____ **Date:** _____

Private Insurance: _____ **Billing Number:** _____