MCIL PAS CONSUMER INTAKE

☐ MA ☐ Waiver ☐ Private Pay ☐ UCare/Axis ☐ Other
*Hrly Rate:*________________

Name__________________ ____________________ ________
(Last) (First) (MI)

Address:____ APT # ________ County: __________

City: ______________________________ State: ________ ZIP:________________

PH:(hm)______________________ (wk) _____________________ (cell) ____________________

Email: __________________________________

DOB:_______________ MA # _______________________ Renewal Date: _____________

Guardian: ☐ Self ☐Other: ________________________________ Relationship:______________

PH: (hm) ______________________ Other: ____________________

Primary ICD9: _______ _______________________ Secondary ________ ____________________
Code *Disability* *Code* *Disability*

Allergies:____

Primary/Referring Physician: ______________________________ Clinic:______________________

Address:____

PH: ______________________ FAX ______________________

Case Mgr: _________________________________

☐ CADI ☐ TBI ☐ EW ☐ AC ☐MR/RC

PH: ________________________ FAX: _______________________

Emergency Contact: _________________________________ PH: ________________________

Address:____

Start Date ____________________ Date Service Agreement Requested:__________________
Received:__________________

PCA Allocation: __________ __________ ____________
Hrly *Daily* *Annual*

Flexible Use only: __________ ____________________ __________ ____________________
Hrs *Start/End Dates* *Hrs* *Start/End Dates*

☐ **PCA Choice** ☐ **Traditional PCA**

Scheduling: ☐ Mornings ☐ Afternoons ☐ Evenings ☐ Overnights ☐ Weekdays ☐ Weekends
Training Supports: ☐ Orientation ☐ Bowel Care ☐ Bladder Care ☐ Seizure Protocol

PCA Preferences: ☐ Male ☐ Female ☐ Either ☐ Non-smoker ☐ Driver's License ☐ Car ☐ Other (note on back page)