Elites Care

Client Intake Form

Date: _____

Individual name_____

Individual Medicaid Number: _____

Individual Waiver type: ☐FIS ☐CL ☐ Other _____

Sex: M_____ F_____ DOB: _____

Street_____City_____State____ZipCode_____County_____

Home phone: _____. Work phone: _____. Cell phone: _____

Staffing Preference: Male ☐ Female ☐

Authorized Representative Contact:_____

Individual present residence (check one)

Home_____ Hospital_____ Residential Treatment Center _____Group Home___

Foster Home_____ Other (specify) _____

Reason for requesting services (Supports Needed)

_____

_____

Preferred Support Schedule: (Ex: Monday – Friday: 9am-5pm)

Support Coordinator:_____ CSB:_____