Intake Form

Does the participant have a waiver eligibility? Yes No

If yes, please answer the following questions:

Care Management Agency: ____________________________________

Care Manager Name: ____________________________________

Care Manager Phone Number: ____________________________________

Care Managers Email: ____________________________________

Does the participant have Self-Direction? Yes No

Are you in the process of transitioning to Self-Directions? Yes No

If yes, please answer the following questions:

Self-Direction Broker Name: ____________________________________

Self-Direction Broker Phone Number: ____________________________________

Self-Direction Broker Email: ____________________________________

Fiscal Intermediary Agency: ____________________________________

Fiscal Intermediary Coordinator's Name: ____________________________________

Fiscal Intermediary Coordinator's Email: ____________________________________

CAP personnel only:

ICD-10 CODE: ____________________________________

Intake Notes:

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