

Fax To: INTAKE Department, WRAAA

(216) 472-4812 Telephone: (216) 621-0303 Fax: Area Agency on Aging ☐ Assisted Living Assessment Type of Request: ☐ PASSPORT Assessment ■ Nursing Home Placement Referent: Agency: Phone: Pager: **CLIENT Name:** Address: Phone: (H) (W) **PRIMARY CONTACT** Name: Relationship: Address: Phone: (H) (W) **LEGAL Guardian:** ☐ YES □ NO POA: ☐ YES Name: Relationship: Address: Phone: (H) (W) **DEMOGRAPHICS**: SEX: ☐ Male ☐ Female Date of Birth: SS# Medicaid# Medicare# Other Insurance? Medicaid HMO: YES NO Type _____ PHYSICIAN's Name: Address: County Phone: Fax: Language / Communication Barrier: YES NO (hard of hearing / confused / aphasia / language[s] spoken) Language / Communication Issues: **DIAGNOSIS:** Primary: Other: Is there a diagnosis of dementia, Alzheimer's, organic mental disease, mental illness, MR/DD? ☐ YES □ NO **FUNCTIONAL** (check all that apply) **FINANCIAL** ☐ Age Consumer's Monthly Income PASSPORT 60+ Assisted Living 21+ Needs hands-on help with ADL's Consumer's Assets (Bathing, Grooming, Dressing, Toileting, Mobility/Transferring, medication Assist) ☐ Needs hands-on help with IADL's Joint Assets (Banking, Phone, Meal Prep, Laundry, Shopping Transportation)

Transfer of Assets (within past 3 years)

☐ YES

Needs 24 Hour Supervision due to Dementia