Western Reserve
Area Agency on Aging

Fax To: INTAKE Department, WRAAA

Fax: (216) 472-4812 Telephone: (216) 621-0303

Type of Request:	☐ PASSPORT Assessment	☐ **Nursing Home Placement**	☐ Assisted Living Assessment

Referent: _____

Agency: _____

Phone: _____

Pager: _____

CLIENT Name: _____

Address: _____
Street City County Zip

Phone: (H) (W)

PRIMARY CONTACT

Name: _____ Relationship: _____

Address: _____
Street City County Zip

Phone: (H) (W)

LEGAL Guardian: ☐ YES ☐ NO POA: ☐ YES ☐ NO

Name: _____ Relationship: _____

Address: _____
Street City County Zip

Phone: (H) (W)

DEMOGRAPHICS: SEX: ☐ Male ☐ Female Date of Birth: _____

SS# _____ Medicaid# _____ Medicare# _____

Other Insurance? _____ Medicaid HMO: ☐ YES ☐ NO Type _____

PHYSICIAN's Name: _____

Address: _____
Street City County Zip

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 _____ PASSPORT 60+ Assisted Living 21+	_____ Consumer's Monthly Income
☐ Needs hands-on help with ADL's (Bathing, Grooming, Dressing, Toileting, Mobility/Transferring, medication Assist)	_____ Consumer's Assets
☐ Needs hands-on help with IADL's (Banking, Phone, Meal Prep, Laundry, Shopping Transportation)	_____ Joint Assets
☐ Needs 24 Hour Supervision due to Dementia	Transfer of Assets (within past 3 years) ☐ YES ☐ NO