KHOBCARE HOME HEALTHCARE AGENCY
Special Needs Program

Confidential Intake Forms

County of Residence ________________ Serial # ________________ Date of Report ____/____/______

Patient Information

Patient's Name ____
Last First MI Maiden

Patient's Alias ____
Last First MI

Guardian's Name ____
Last First MI

Patient's Date of Birth ______/______/______ Patient's Age ______ Patient's Country of Birth ______________

Patient's Primary Phone No. (______)______ - ________ Patient's Secondary Phone No. (______)______ - ________

Patient's Physical Address ____
Number & Street City Zip Code

Patient's Mailing Address (if different) ____
City Zip Code

Who is over your care
- ☐ Mother
- ☐ Father
- ☐ Attorney
- ☐ Sister
- ☐ Brother
- ☐ Cousin
- ☐ Spouse
- ☐ Care Facility
- ☐ Other ____________
- ☐ The State

Medical Conditions
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________
- ☐ ____________

Sex
- ☐ Male
- ☐ Female
- ☐ Unknown

Pregnant
- ☐ Yes
- ☐ No
- ☐ Unknown

If Pregnant Due Date: ____/____/____

Race (Check all that apply)
- ☐ White
- ☐ Black
- ☐ Amer. Indian /Alaskan
- ☐ Asian ____________
- ☐ Native Hawaiian/ Pacific Islander ____________
- ☐ Other
- ☐ Unknown

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Does the patient live alone? Yes No Unknown If yes, Does the patient have assistance when needed? Yes NO

Diagnosis Described: ________________ Currently Under Physician Care? ________________

Date of First Symptom: ______/______/______ Date of Diagnosis ______/______/______

Hospitalized? ☐ Yes ☐ No ☐ Unknown Physician Contact Number: ________________

Primary Physician ______________________________

Date Of Last Physical ______/______/______ Date Of Next Physical ______/______/______

Reporter Information

Reporting Individual ______________________________ Telephone (______) ______ - ______

Address ____

What goals would you want for the client listed above?
____
____
____
____

Comments

What major health issues should we be concerned with DSP care: ______________________________
____
____

Khobcare Special Needs Health Department Use

Caregiver Status
- ☐ Assigned
- ☐ Processing
- ☐ Unmatched
- ☐ Denied

Client Status
- ☐ Confirmed
- ☐ DENIED
- ☐ Undecided
- ☐ Unknown

Khobcare Special Needs Department Signature ______________________________

Date Form Received ______/______/______

Official Start Date Of Care ______/______/______

Was Patient Notified?
- ☐ Yes
- ☐ No
- ☐ Unknown

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