Help Them Grow

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Social Security Intake

Today's Date:	How did you hear about us?
Name (Of person with Disability):	
Your Name (Person Completing Paperwork):	
Relationship to Person with Disability:	
Place of Birth?	
Adopted? (If so, date of Citizenship, date arrived in US)	
How often do you spend time together?	
What do you do together?	
How Long have you known this person?	

Information pertaining to person with disability

Date of Birth:	
Street Address:	Medicaid Number (If Applicable):
City, State, and Zip Code:	Social Security Number: (provide copy)
County of Residence:	Country of Citizenship (If other than U.S.):

Caregiver/Parent

Name:	Phone:
Employer:	Email:
Relationship to Applicant:	Relative's Phone:
Insurance:	Policy and Group Number:
SSN:	Date of Marriage:
Yearly Income (provide paystubs or taxes)	Do you live in a house, mobile home, houseboat?
Savings (provide copy)	Stocks/Bonds (provide copy)

Physician Who Will Be Signing Forms

Primary Physician:	Phone Number:
Street Address:	City, State, and Zip Code:
When did you first see this doctor?	When did you last see this doctor?
When is your next apt?	What does he/she treat you for?

This person can
☐ Speak and Understand English? ☐ Write and Read English? ☐ Can write more than your name in English?
What other languages do you speak if you don't speak English? _____

1) Give the name of someone, other than your doctors, (who can be contacted) who knows about your condition?
   Maiden Name (if applicable) _____
   a) Name _____ b) Relationship to Applicant _____
   c) Daytime Phone _____
   d) Mailing Address _____City _____ State _____ Zip _____
   e) What is your preferred language? _____

2) Medical Conditions that affect applicants ability to function independently.
   _____
   _____
   _____
   _____
   _____

3) Applicant's Height and Weight _____inches _____ pounds
4) Does your conditions cause you pain? _____
5) Do you work? _____
6) If you have worked in the past, when did you stop working? _____

7) What is the highest grade completed? ☐ 10 ☐ 11 ☐ 12 ☐ GED or MORE List College if completed.
   a) Name and Address of most current school attended. _____
   b) Dates Attended From _____ To _____
   c) Have you completed any type of specialized job training or trade or vocational school?

8) Any jobs you have had in the last 15 years
   a) Type of Job ______________ From __________ To __________ Days per week ________ Rate of Pay ________

9) Please list all Medication below:

Name of Medication	Give name of Doctor who Prescribed	Reason for the Medicine

10) Physician's that you have seen.

Name of Practice ____________________________________ Doctor's Name and Specialty _______________________
Mailing Address _____________________________________ City ___________________________ Zip _______________
Phone: ________________________ Date of First Visit _________________ Date of Last Visit _____________________
Any Emergency or Overnight Hospital Stays? Admitted ______________ Released _____________Duration ____days.
Next scheduled appointment: __________________________ What were you treated for? ________________________
What treatment did you receive? ____

Name of Practice ____________________________________ Doctor's Name and Specialty _______________________
Mailing Address _____________________________________ City ___________________________ Zip _______________
Phone: ________________________ Date of First Visit _________________ Date of Last Visit _____________________
Any Emergency or Overnight Hospital Stays? Admitted ______________ Released _____________Duration ____days.
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Name of Practice ____________________________________ Doctor's Name and Specialty _______________________
Mailing Address _____________________________________ City ___________________________ Zip _______________
Phone: ________________________ Date of First Visit _________________ Date of Last Visit _____________________
Any Emergency or Overnight Hospital Stays? Admitted ______________ Released _____________Duration ____days.
Next scheduled appointment: __________________________ What were you treated for? ________________________
What treatment did you receive? ____

1. Where does he/she live? At home? In an apartment? In an institution? ____________________________________

2. With whom does he/she live? ____

3. Does this person have dependents? List them and their relationship to him/her.
____

4. If so, what does he/she do for them? Does he/she care for them, etc. ______________________________________

5. Does this person have pets?_____

6. If so, what does he/she do for them? Is he/she responsible for the pets' care? _____

7. Does he/she have assistance of any kind in the home? _____

Has this person's illness affected any of the following aspects of his/her life and personal care? Check all that apply, and provide a brief explanation of how they have been affected.

	Sleeping	
	Communication	
	Motor Function	
	Socialization	
	Dress	
	Bathing	
	Hair Care	
	Shaving	
	Feeding	
	Using the toilet	

1) Does he/she need prompting and reminding to take care of his personal hygiene? _____

2) Does he/she need prompting and reminding to take medication?_____ 1.

3) Does this person prepare his/her own meals? If so, what special accommodations does he need to perform this task? If no, why?

Mealtimes

1. Does this person prepare his/her own meals? If so, what special accommodations does he need to perform this task? If no, why? _____

1) How often does he/she prepare meals?_____

3) How long does this task take?_____

4) Is eating difficult for him/her? Why? _____

5) Does he/she need/receive help during preparation or consumption of food? _____

Applicant's Abilities

Check any of the following that the applicant is unable to perform due to his/her illness:

	Lifting		Squatting		Bending
	Standing		Reaching		Walking
	Sitting		Kneeling		Talking

	Hearing		Stair Climbing		Seeing
	Memory		Completing Tasks		Concentration
	Understanding		Following Instructions		Using Hands
	Getting Along with Others				

Please List any other Information _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____