



CLIENT INTAKE FORM

Please complete and return to

For Office Use

New
 Change
 Deceased

AIMS Client Number (*office use*)

Volunteer: _____

Date: _____ Site: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ County: _____

City, State, Zip _____ Home Phone: _____

Social Security #: _____ Are you a veteran or the spouse of a veteran? *Yes No*

Gender: *Male Female* Date of Birth: ____/____/____ Age: _____

Race/Ethnicity: *African American Caucasian Hispanic/Latin Native American Other*

Marital Status: *Married Not Married Widowed* Employment Status: _____

Number of people living in household (including client): ____ Legal resident of the U.S.? *Yes No*

Primary Physician:

	Name	Address	Phone
--	------	---------	-------

Second Physician:

	Name	Address	Phone
--	------	---------	-------

Emergency Contact:

	Name	Phone	Relationship
--	------	-------	--------------

HOUSEHOLD INCOME

(We **MUST HAVE** a copy of proofs of income for ***EVERYONE*** who lives in your household.)

Social Security \$ _____	Interest Income \$ _____	TOTAL MONTHLY INCOME \$ _____ TOTAL ANNUAL INCOME \$ _____ <i>Qualification Level % _____</i>
Disability \$ _____	Spouse Income \$ _____	
Pension \$ _____	Other Income \$ _____	
Wages/Salary \$ _____	Child Support \$ _____	

Tax Return or SSA 1099 Provided: *Yes No* **Documents Needed:** _____

TOTAL AMOUNT OF ASSETS \$		TOTAL AMOUNT OF EXPENSES \$	
Checking	\$ _____	Mortgage/Rent	\$ _____
Savings	\$ _____	Insurance	\$ _____
CD's	\$ _____	Utilities	\$ _____
Other	\$ _____	Car Expenses	\$ _____
Value of <u>Secondary</u>	\$ _____	Phone/Cable	\$ _____
Real estate	\$ _____	Food/Supplies/Other	\$ _____

The Alabama Department of Senior Services, through 13 Area Agencies on Aging, administers this program statewide. The information being collected will be kept **STRICTLY CONFIDENTIAL**.



Last Name: _____

MEDICAL INFORMATION

Medicare # _____ Medicaid # _____ QMB SLMB Referred to SHIP:
Private Insurance # _____ Company: _____ Prescription Coverage: Yes No
Are you enrolled in another prescription assistance program? Yes No Which Ones: _____

Medical Expenses Monthly Prescription Cost \$ _____ Doctor/Hospital/Lab fees \$ _____
Non-prescription Medication Cost \$ _____ Medical Supplies \$ _____

TOTAL MEDICAL EXPENSES Monthly \$ _____ Annually \$ _____

CURRENT MEDICATIONS: *Please List all of the Client's Current Medications*

Available	Medication Brand Name	Dosage	Manufacturer	Directions	Physician	Cost	Eligible
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No
Yes No						\$	Yes No

For Office Use Only: Total Number: _____ Number Applied: _____

Pharmaceutical Discount Cards: _____

Medication Allergies: _____

Primary Diagnoses: _____

I hereby state that the information I have given is correct to the best of my knowledge and the **SENIOR Rx** Program has my permission to obtain and release information as deemed necessary. I understand the **SENIOR Rx** Program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services. Signature: _____ Date: _____

This information will be kept STRICTLY CONFIDENTIAL and will expedite the application process.