

**MI Options Intake (Non-RiverStar) Referral Form
PCOC/SHIP/MIPPA Programs**

PCOC SHIP/MIPPA PCOC/SHIP/MIPPA

CLIENT INFORMATION

Intake Date: _____ Crisis Situation: _____
Name: _____ DOB: _____ Age: _____
Address: _____ City: _____, Zipcode: _____
Phone: _____ Email: _____
Preferred contact method: _____ Ethnicity: _____
Primary language: _____ Gender: _____ Race: _____
Marital Status: _____ Spouse/Significant Other Name: _____
Medically Disabled: _____ Veteran: _____
Reason for Referral: _____
Referral Completed By: _____ Phone: _____

CLIENT SURROGATE INFORMATION

Name: _____ Phone: _____
Address: _____ City: _____, MI ZIP: _____
Email: _____ Relationship to client: _____
Surrogate's Preferred contact method: _____

PCOC: CLIENT HEALTH STATUS

Is expected to need LTSS for a period longer than a month: _____
Has experienced a fall within the last month: _____
List health conditions, illnesses or disabilities that have created the need for LTSS: _____

List care provided within last month: _____
Is the client a caregiver: _____

SHIP/MIPPA: CLIENT HEALTH COVERAGE & FINANCIAL INFORMATION

Does client receive Medicare or employer health coverage: _____
If yes, Health Insurance information: _____
Does client receive or applied for the following: SSDI _____ SSI _____ VA _____ Other _____
Is client currently employed: _____ Does client have a Medicare.gov account: _____
Fax to: _____