Client Intake for In-Person Visit

Staff/Volunteer Name: ____________________ **Date of Contact:** ___________

Location: ______________________________________ **Total Time:** __________

Basic Information

Name: ____

Address 1: ____________________________ **Address 2:** ____________________

City: ____________________ **State:** ____ **Zip:** ______ **County:** ____________

Phone Number: _____________ **Email:** ________________________________

DOB: ____________ **Gender:** ____ **Living Situation:** _____________________

Currently Living with: ________________ **Marital Status:** _________________

Employment Status: ____

Ethnicity (list all that apply): ______________________________________

Languages spoken (if not English): ___________________________________

Interpreter Needed? ☐ **Yes** ☐ **No**

Veteran: ☐ **Yes** ☐ **No** **Relationship to Veteran:** ______________________

Veterans Benefits: ____

How heard about SLL: ____

Caregiver Information

Name/Organization: ____

Relationship to Consumer: _______________

Address: ________________________________

City/State/Zip/County: ____

Phone: _____________________________ **Email:** _______________________

Does the caregiver live with the care receiver: ☐ **Yes** ☐ **No**

Benefits

Unearned Monthly Income (SSA): $ ________ Earned Income: $ ___________

Income FPL: ☐ At or Above 150% ☐ Below 150%

Number in Household: _________ Assets: $ _____________________________

Asset FPL: ☐ Above LIS Asset Limit ☐ Below LIS Asset Limit ☐ Not Collected

Medicare Number: ____________________

Start Dates Part A: ___/___/___ Part B: ___/___/___

Has a Disability? ☐ No ☐ Refused ☐ Yes

- **If Yes, Received a Determination: ☐ Yes ☐ No ☐ In Process**

SLL Created MyMedicare Account: ☐ Yes ☐ No

Type of Enrollment Completed: ____
(Include a printout of plan finder tool's confirmation and cost summary)

Type of Application Assistance Provided: ________________________________

Eligible for Extra Help (LIS): ☐ Deemed ☐ Yes ☐ No ☐ Not Collected

Eligible for Medicare Savings Programs (MSP): ☐ Yes ☐ No ☐ Not Collected

# of PAP Applications: ________ # of Drugs Covered by PAP: ________

Estimated Annual Savings through PAP: _________________

Other

Materials Provided: ____

____

SLL Community Survey Given: ☐ Yes ☐ No

Follow-Up Instructions:

Notes: