Intake Application

Applicant's Personal Information:

NOT *info on Guardians, Parents, or Legal Representatives*

Legal Last Name:		
Legal First Name:		
Middle Initial:		
Social Security Number:		
DOB:		
City & State of Birth:		
Gender:	☐ Male ☐ Female ☐ Other: ____________________ ☐Transgender Male ☐ Transgender Female	
ADL or State ID #:		
Contact Name:		
Cell Phone (best # to reach applicant, state whose # if not applicant)**:**		
Email Address:		
Preferred Contact (Choose One)**:**	☐ Email ☐ Phone ☐ USPS	
Care Coordinator or Other Person Assisting:	First & Last Name: ____ Phone Number: _________________________ ☐ Care Coordinator ☐ Referral Service ☐ Other: _______________	
Are you currently receiving services from other providers:	**Provider Name**	**Service Type**
Have you applied for services with other providers:	**Provider Name**	**Service Type**
Physical Address:		
Mailing Address:		
Ethnicity:		
Primary Language:		
English Fluency (Choose one)**:**	☐ Excellent ☐ Good ☐ Moderate ☐ Poor	
Citizenship:	☐ U.S Citizen ☐ Certificate of Naturalization ☐ Certificate of Citizenship ☐ Other: ________________________	
Health Insurance (Answer each question)**:**	Health Insurance provided through guardian:	☐ Yes ☐ No
	Primary Insurance:	

	Policy #:	
	Group Name:	
	Group Member:	
	Insurance Address:	
	City, State, Zip:	
	Policy Holder:	
Applicant has Medicaid, Denali Kid Care, or TEFRA Coverage?	☐ Medicaid #:_______________________ ☐APDD ☐ISW ☐IDD ☐CCMC ☐MH Medicaid ☐Private Pay ☐Other: ____________ ☐ Denali Kid Care ☐ TEFRA	
Applicant has Medicare Coverage?	☐ Yes, Medicare Number: _____________________________ ☐ No	
Does the applicant receive any other medical assistance?	☐ APA ☐ SSI ☐ Other:_________________________	
Anticipate current medical assistance eligibility to end in the near future?	If yes, explain:	
Medical Information	Primary Care Physician	
	Date of Last Physical	
	Neurologist Name	
	Date of Last Psychological Evaluation	
	Dentist Name	
	Date of Last Exam	
	Optometrists (vision) Provider	
	Date of Last Exam	
	Gynecologist/OBGYN Provider	
	Date of Last Exam	
	Preferred Pharmacy	
	Other	
Diagnostic Information:	1. Provide the name of ALL diagnosis: 2. Age and/or Date of first diagnosis: 3. Last time reassessed:	

List of Current Medications:	Name	Dose	Frequency

The Arc of Anchorage

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Allergies (Please list all types of allergies – food, environmental, medications, etc.):	Allergy To	Reaction
Services being requested (Check all that may apply):	☐ Case Management ☐ Family Home Habilitation ☐ Group Home ☐ Supported Living ☐ In-Home Supports ☐ Day Habilitation ☐ Supported Employment ☐ Respite ☐ Nursing Oversight ☐ Other: ___________________	☐ Behavioral Health Services ☐ Pharmacological Management ☐ Psychotherapy ☐ Community Recovery Support ☐ Adult Mental Health Residential Facility ☐ Other: __________________
How did you hear about The Arc?		

Read and Initial each of the following statements:

___ I certify, under penalty of perjury, that the information on this application is true and complete statement of facts according to my best knowledge and belief.

___ I understand that AI may be asked to provide proof of any information given on this application.

___ I understand that if this information substantially changes or services are no longer needed, I must notify The Arc of Anchorage.

___ I further understand that I am committed to participating in the service planning, including meetings and service delivery.

____ ____________________

First & Last Name Date

____ ____________________

Signature of Applicant Requesting Services Date

____ ____________________

Signature of Legal Representative Date