INITIAL PERSONAL CARE ATTENDANT SERVICES INTAKE FORM

Date: _____

Applicant's Name: _____

Primary Address: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Male ☐ Female ☐

Referred by: _____ Relationship: _____

Contact Information of Referral (phone/email): _____

Additional Contact: _____

Legal Guardian (if applicable): _____

MassHealth Number: _____

*MassHealth Standard and MassHealth Commonhealth coverage only

Primary Diagnosis: _____

Which of the following areas does the individual need physical assistance:

☐ Mobility ☐ Transfers ☐ Bathing ☐ Grooming

☐ Dressing/Undressing ☐ Toileting ☐ Eating ☐ Medications

☐ IADL's (Meal Prep/Laundry/Housekeeping)

Comments/Notes: _____

_____

_____

Completed by:

Name: _____ Date: _____

Please submit to: PCA Department, UCP of MetroBoston, 71 Arsenal Street Watertown, MA 02472