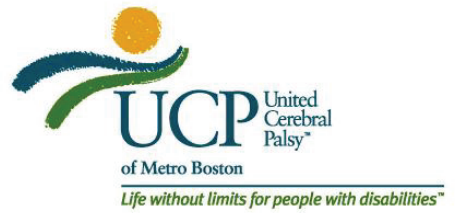


INITIAL PERSONAL CARE ATTENDANT SERVICES INTAKE FORM



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 Commonwealth 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