



Dementia Support Services Program
CONSUMER INTAKE FORM

Date of Referral: _____

Tab ID: _____

Consumer Information

Consumer's First Name

M.I.

Consumer's Last Name

Address

City

State

Zip Code

()

Phone Number

MSC Information

MSC First Name

MSC's Last Name

Agency Affiliation

Address

City

State

Zip Code

()

Phone Number

Email address

Family/ Legal Rep. / Advocate Information (person responsible for consumer's care)

First Name

Last Name

Relationship

Address

City

State

Zip Code

()

Phone Number

Email address

Residential Information

Res. Mgr. First Name Res. Mgr. Last Name Agency Affiliation

Address

City State Zip Code

()

Phone Number Email address

Type of Residence:

____ Own Home ____ CR ____ Supportive Apartment
____ Family Home ____ ICF ____ Family Care Home
____ IRA ____ SNF Other, please specify _____

Number of individuals in the household: _____

Day Services Information

Program Type:

____ Day Hab ____ Day Treatment ____ Adult Day Program
____ In Home ____ Sheltered Workshop Other, please specify _____

Day Services Primary Contact:

First Name Last Name Name of Agency

Address

City State Zip Code

()

Phone Number Email address

INFORMATION ABOUT CONSUMER

1. **Consumer's gender** ____ Male ____ Female
2. **Consumer's marital status** ____ Single ____ Married/Domestic Partner ____ Widowed ____ Other
3. **Consumer's date of birth** ____ Month ____ Day ____ Year

4. What is the consumer's race / ethnicity?

- | | |
|--|--|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Other Hispanic/Latino |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> American Indian or Alaskan Native |
| <input type="checkbox"/> Mexican | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Other |

5. In which language(s) is the consumer fluent? (Check all that apply)

- English Spanish
- Other (Please specify.) _____

6. Consumer's Primary Physician: _____

Address: _____ Phone Number: _____

7. Consumer's Social Security # _____

8. Medicare # _____

9. Medicaid # _____

10. Other Insurance (Type) _____ ID Number: _____

11. Has the consumer been diagnosed with Alzheimer's disease or other dementia? _____

**Please note, if memory problems are suspected but a formal diagnosis has not been made we can still consider the application but a formal evaluation will be requested upon intake.*

12. Current Diagnosis (be sure to include the developmental disability):

13. How often does consumer need help with each of these activities?

Activity	Needs No help (No Supervision)	Needs Some Help (Occasional Supervision)	Needs a lot of Help (Constant Supervision)	Can not Do it at All
(a) Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Getting around inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Doing heavy housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Doing light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activity	Needs No help (No Supervision)	Needs Some Help (Occasional Supervision)	Needs a lot of Help (Constant Supervision)	Can not Do it at All

			Supervision)	
(i) Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Cooking/preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Buying/getting food/clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Getting around outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Going places outside of walking distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Taking medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(p) Using telephone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How often have you, the caregiver observed the following behaviors in the consumer?

Behavior	0 (no days)	1-2 days	3-4 days	5/more days
(a) Keeps you up at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Repeats questions/stories.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Tries to dress the wrong way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Has a bowel or bladder "accident".	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Hides belongings and forgets about them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Cries easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Acts depressed or downhearted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Clings to or follows you around.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Becomes restless or agitated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Becomes irritable or angry.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Swears or uses foul language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Becomes suspicious or believes someone is going to harm (him/her).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Threatens people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Shows sexual behavior or interest at wrong time/place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(o) Wanders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete and Mail to:

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