
**COVENANT CARE SERVICES LLC**
**40 Gina Street, Lewiston, ME 04240**
**TEL: 207- 252-8470**
**FAX: 207-601-3590**
**contact@covenantcareservices.org**

# CLIENT / RECIPIENT INTAKE FORM

## WHO IS COMPLETING THIS FORM

☐ Client Family ☐ member ☐ Guardian ☐ Case manager ☐ Hospital discharge planner

## CARE RECIPIENT INFORMATION

First Name: _____

Last Name: _____

Middle Initial: _____

Gender:
○Male ○ Female ○ Other

Date of Birth (MM/DD/YYYY): _____

Social Security Number: _____

MaineCare ID Number: _____

Phone Number: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Living Alone:
○ Yes ○ No

Marital Status:
○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Languages Spoken:
☐ English ☐ Spanish ☐ French ☐ Other: _____

**LEGAL STATUS**

Responsible for Self
○ Yes ○ No

Responsible Party / Guardian

Name: _____

Phone: _____

Mobile: _____

**EMERGENCY CONTACT INFORMATION**

Primary Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Mobile: _____

Email: _____

Secondary Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Mobile: _____

**SERVICES REQUESTED**

Please check all that apply:

☐ Personal Care Assistance (PCA)

☐ Homemaker Services

☐ Home Health Services

☐ Transportation Assistance

☐ Home Meal Delivery

☐ Housing Support

☐ Case Management

☐ Other: _____

**INSURANCE INFORMATION**

Insurance Provider: _____

Policy Number: _____

Member ID: _____

Policy Holder Name: _____

☐ No Insurance

**PHYSICIAN INFORMATION**

Physician Name: _____

Clinic / Facility Name: _____

Facility Address: _____

Telephone Number: _____

**MEDICAL INFORMATION**

Diagnosis / Medical Conditions

_____

_____

_____

Additional Comments

_____

_____

_____

**SIGNATURES**

Care Recipient Signature

Signature: _____

Date: _____

Responsible Party

Signature: _____

Date: _____

Agency Representative

Signature: _____

Date: _____

RN / Qualified Professional

Signature: _____

Date: _____