Panhandle Independent Living Center

CONSUMER APPLICATION AND INTAKE RECORD

Intake by: _____ Intake Date: ___/___/___

First Name: _____ MI:_____ Last Name: _____

Address: _____ Mailing: _____

City: _____ State: TX Zip: _____ County: _____

Phone/TDD: _____ Preferred Contact: Email __ Text__Phone__Letter___

Email/Text Number _____

SS#: _____ Medicaid#: _____ Medicare#: _____

DOB: ___-___-_____ Age: _____ Sex: ( ) Male ( ) Female

Ethnic Group: ( ) American Indian/Alaskan Native ( ) Asian ( )Black/African American

( )Hispanic/Latino ( )Native Hawaiian/Pacific Islander ( )White

Age Category: ( )Under 6 ( )6-17 ( )18-22 ( )23-64 ( )65 & Over ( )Unknown

Living Situation: _____

Domestic Status: ( ) Dependent Child ( ) Divorced ( ) Married/Adult in Family

( ) Separated ( ) Single/not in family ( ) Widowed

Source of Income: _____ Monthly Amount: _____

Employed: ( )Yes ( )No Employer Name: _____

Employer Address: _____ Phone: (806) _____

Length of Employment: _____ Last Grade Completed _____

Primary Disability: _____ Specific: _____

Secondary Disability: _____ Specific: _____

Date of Onset: _____ Age of Onset _____

Primary Physician: _____ Phone: _____

Wheelchair Access: ( )Yes ( )No Communication/Mobility Aids: _____

Transportation: _____

Type of Assistance: _____

Referral from: _____ Referral to: _____

Agency Name: _____ Counselor: _____ Phone: _____

Emergency Contact & Phone _____ Relation: _____

Consumer Eligibility: ( )Yes ( )No Waiver Signed: ( )Yes ( )No

Applicant's Signature _____

Date Closed: _____ Date Reopened: _____