Council on Aging
131 West Tyler Street, Suite 1A, Elkhart, IN 46516
PH: 574-295-1820 FAX: 574-294-5924

CLIENT APPLICATION

New Client: ☐
Update: ☐

Name: _____

Street Address: _____ **Apt:** _____ **Floor:** _____

City: _____ **Zip:** _____ **Township:** _____

Residence: ☐ Single Dwelling ☐ Apartment Complex ☐ Mobile Home
☐ Skilled Nursing Facility ☐ Independent Living Facility ☐ Duplex

Individuals in Home: ☐ Self only ☐ Spouse ☐ Other: _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Sex: ☐ M ☐F **DOB:** _____ **Age:** _____

Race/Ethnicity (select all that apply): ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan
☐ Hawaiian / Pacific Islander ☐ Other ☐ White

Hispanic: ☐ Yes ☐ No **Social Security #:** _____

Marital Status: ☐ S ☐ M ☐ W **Spouse Name:** _____

EMERGENCY CONTACT *(individual not living with you)*

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Email: _____

Name of POA or Legal Guardian: _____ Phone: _____

Address: _____

INCOME VERIFICATION

Responsible Party: _____

Total Household Income: _____ No. of Residents in Home: _____

Head of Household (HOH) Name: _____

Sex of HOH: ☐M ☐F Relationship to HOH: _____ HUD Housing: ☐ Yes ☐ No

Sources of Income*: _____

Current Employer: _____

Insurance Provider: _____ Insurance Coverage for: ☐ Transportation
☐ Homemaking
☐ Attendant Care

Medicaid #: _____ Medicare #: _____

Veteran's Information (DD214): _____

**Copy of income documentation must be provided as verification (eg, DD214 Letter from Medicare, pension statement)*

PERSONAL CARE

Degree of Ambulation: ☐ Unassisted ☐ Assistance while walking ☐ Cane ☐ Walker ☐ Wheelchair

Wheelchair Specifications: ☐ Extensions ☐ Reclining ☐ Folding ☐ Motorized Size (width): _____

Self-transfer to and from Vehicle: ☐ Yes ☐ No

Oxygen Requirement: ☐ Yes ☐ No

Major Health Concerns: _____

Recent Hospital Admissions: _____

Primary Care Physician: _____ Phone: _____

Dietary Restrictions: _____

SERVICES REQUESTED

☐ Transportation ☐ Homemaking ☐ Attendant Care ☐ Respite

☐ Medicare Savings Program ☐ Money Management ☐ Site Participation ☐ Referral/Reference

☐ Other: _____

How did you hear about Council on Aging of Elkhart County? _____

_____

AUTHORIZATION

I am aware, by accepting Council on Aging services, my information will be released to the funding sources (e.g., Elkhart and Goshen CDBG, United Way, Real Services) utilized for payment of services received. The information released is private and subsequent use and release of this information is to be treated as such. I am informed payment will be denied if the release of such information is denied. I hereby consent to the release of necessary information for the purpose of satisfying the requirements set forth by the funding source. Initial _____

I hereby acknowledge receipt of the COA HIPAA Privacy Practices. Initial _____

I hereby acknowledge receipt of the current year Fee Schedule. Initial _____

I hereby acknowledge receipt of the Program Policies and Guidelines. Initial _____

By signing, I am acknowledging the information disclosed is accurate at presented. Sponsored by: REAL SERVICES United Way

Client Signature: _____ Date: _____

OFFICE USE ONLY

Form received: _____ By: _____

Initial contact: _____ By: _____

Service established: _____ By: _____

Copy to Dept Mgr: _____ Dept: _____ By: _____

Interviewer: _____ Referred by: _____

Payor Source: _____ Approved by: _____ Date: _____

Client List Updated: _____ Scanned: _____