

Client Intake Form



Referral (please circle)

Type: My Aged Care NDIS Under 65 Self/family		
Today's date:	Start date:	Run:

Client details

Title:	Gender:
First name:	Date of birth:
Surname:	Country of birth:
Street address:	
Suburb and postcode:	
Home phone:	Mobile:
Email:	
Language at home:	Cultural background:
Are you Aboriginal or Torres Strait Islander? Yes No Prefer not to state	
Medicare number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ref <input type="text"/>	Expiry: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

My Aged Care clients

My Aged Care account number: A/C <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> /not registered	
Home Care Package level:	/no home care package
Home Care Package provider:	/no provider
Provider contact person:	/no contact person
Provider phone:	Email:
Permission for MOW to contact provider: Yes No	

NDIS clients

NDIS plan number:	
Plan dates: / / to / /	
Are you: Self Managed Plan Managed (PM) NDIA Managed	
PM Company:	
PM name:	
PM phone:	Email:
Permission for MOW to contact PM: Yes No	

Client Intake Form



Primary contact

First name:	Surname:
Relationship:	
Address:	
Phone:	Email:

Secondary contact details

First name:	Surname:
Relationship:	
Address:	
Phone:	Email:

Client dietary requirements

	YES	NO	DETAILS
Food allergies?			
Food intolerances?			
Pureed or cut meals required?			
Problems with chewing?			
Problems with swallowing?			
Problems with opening meals?			
Problems with heating food?			

Household dietary requirements

Does anyone living with you have severe food allergies?			
---	--	--	--

Payment details

I would like to be invoiced: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
I would like my invoice: <input type="checkbox"/> Delivered with my meals <input type="checkbox"/> Emailed _____ <input type="checkbox"/> I do not need an invoice <input type="checkbox"/> Other _____
My preferred payment method is: <input type="checkbox"/> Cash <input type="checkbox"/> Bank deposit <input type="checkbox"/> Cheque <input type="checkbox"/> Square (credit/debit card) <input type="checkbox"/> Centrepay (Centrelink pension)
Payee name:
Payee signature:

Client Intake Form



Home access (OFFICE USE ONLY)

	YES	NO	DETAILS
Is the street number visible?			
Is there a private driveway for parking?			
Are outside pets secured/non-threatening?			
Is the gate easy to open?			
Is the path to door clear?			
Do the outdoor stairs have sturdy railings?			
Is entry via the front door?			
Can client open the door independently?			
Is the entryway clear?			

Checklist (OFFICE USE ONLY)

- AC & Medicare numbers collected and entered into MMS (if applicable)
- Home Access Questions answered- any details added to delivery notes in MMS
- ATSI status entered into MMS (if applicable)
- Referrals &/or Provider contact completed (if applicable)
- Payment Details entered into MMS
- Dietary Requirements entered into MMS- labels created externally (if applicable)
- Forms Scanned and attached to Client file on Sparkle & MMS