The Arc of Anchorage

Intake Application

APPLICANT'S PERSONAL INFO:

***NOT** info on Guardians, Parent, or Legal Reps*

LEGAL LAST NAME:	
LEGAL FIRST NAME:	
MIDDLE INITIAL:	
DOB:	
CITY & STATE OF BIRTH:	
GENDER:	☐Male ☐Female ☐Other _____ ☐ Male to female transgender ☐ Female to male transgender
ADL OR STATE ID #:	
CONTACT NAME:	
CELL PHONE #: Best # to reach Applicant. State who # belongs to if not Applicant.	
EMAIL Address:	
PREFERRED CONTACT: Please choose one	☐Email ☐Phone ☐USPS
CARE COORDINATOR OR OTHER PERSON ASSISTING YOU:	First & Last Name _____ ☐Care Coordinator ☐Referral Source ☐Other_____ Phone Number _____
ARE YOU CURRENTLY RECEIVING SERVICES FROM OTHER PROVIDERS: Provider Names & Service Types	
HAVE YOU APPLIED FOR SERVICES WITH OTHER PROVIDERS: Provider Names & Service Types	
PHYSICAL ADDRESS: Applicants Address	
MAILING ADDRESS: Applicants Address	
ETHNICITY:	
PRIMARY LANGUAGE:	
ENGLISH FLUENCY: Please Choose One	☐Excellent ☐Good ☐Moderate ☐Poor
CITIZENSHIP:	☐US Citizen ☐Certificate of Naturalization ☐Certificate of Citizenship ☐Other _____
HEALTH INSURANCE: Answer Each Question	1. Health Insurance provided through guardian: ☐Yes ☐No 2. Primary Insurance:_____

	3. Policy #:_____ 4. Group Name:_____ 5. Group Member:_____ 6. Insurance Address:_____ 7. City, State, Zip:_____ 8. Policy Holder:_____
APPLICANT HAS MEDICAID, DENALI KID CARE OR TERFA COVERAGE?	☐Medicaid Number: _____ ☐ISW ☐IDD ☐CCMC ☐MH Medicaid ☐Private Pay ☐Other _____ ☐Denali Kid Care ☐Terfa
APPLICANT HAS MEDICARE COVERAGE?	☐Yes - Medicare Number:_____ ☐No
APPLICANT RECEIVES ANY OTHER MEDICAL ASSISTANCE?	☐APA ☐SSI ☐Other: _____
ANTICIPATE CURRENT MEDICAL ASSISTANCE ELIGIBILITY TO END IN NEAR FUTURE?	If yes, Explain.
MEDICAL INFO:	1. Primary Care Physician:_____ 2. Date of Last Physical:_____ 3. Neurologist Name:_____ 4. Date of Last Psychological Evaluation:_____ 5. Dentist Name:_____ 6. Date of Last Exam:_____ 7. OTHER:_____
DIAGNOSTIC INFO:	1. Provide Name of ALL Diagnosis (past/present): 2. Age or Date of 1st Diagnosis: 3. Last time Reassessed:
LIST OF CURRENT MEDICATIONS:	Name: Dose: Frequency: Name: Dose: Frequency: Name: Dose: Frequency: Name: Dose: Frequency:
ALLERGIES: Please list all types of allergies – food allergies, environmental allergies, medication allergies, etc.	Allergy: Allergic Reaction: Allergy Allergic Reaction: Allergy Allergic Reaction: Allergy Allergic Reaction:

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Services being requested – please check all that may apply:	☐Case Management ☐Family Home Habilitation ☐ Group Home ☐ Supported Living ☐ In-Home Supports ☐Day Habilitation ☐Supported Employment ☐ Respite ☐ Nursing Oversight ☐Other: _____ ☐ Behavioral Health Services ☐Pharmacologic Management ☐Therapeutic Behavioral Health Services ☐Comprehensive Community Support Services ☐Psychotherapy
How did you hear about The Arc?	
Read and initial each of the following statements:	_____ I certify, under penalty of perjury, that the information on this application is a true and complete statement of the facts according to my best knowledge and belief. _____ I also understand that AI may be asked to provide proof of any information given on this application. _____ I understand that if this information substantially changes or services are no longer needed, I am required to notify The Arc of Anchorage. _____ I further understand that I am committed to participating in the service planning, including meetings, and service delivery.
Signatures:	_____ _____ Signature of Applicant Requesting Services (required for individuals over the age of 14) Date _____ _____ Signature of Referral Source Date _____ _____ Signature of Legal Representative Date _____ _____ Signature of Staff Member Date