Merrimack Adult Day
Health Center

Participant Intake Form

☐ **Check here if you are updating Participant information for an existing Participant**			
Participant INFORMATION			
Participant Name (Last, First)			**Gender**
DOB:	**Admission Date:**	**Program:**	
		Merrimack Adult Day Health Center	
Participant's Address:			
City:	**State:**	**Zip Code:**	**SSN:**
Phone (Home):		**Phone (Cell):**	
ADMISSION			
Date of Referral		**Reason for Admit**	
Referral Source		**Phone Number:**	
Primary Language		**Participant Race**	
Primary Care MD	**PCP Address**		**NPI#**
PCP Phone		**PCP Fax**	
Emergency Contact / Relationship		**Emergency Contact Address**	
Emergency Contact Phone			
DIAGNOSIS			
Primary Diagnosis ICD 10		**Code Status**	
		MOLST form completed ☐Yes ☐No	
Additional ICD 10	**Additional ICD 10**	**Additional ICD 10**	
Additional ICD 10	**Additional ICD 10**	**Additional ICD 10**	
FINANCIAL ELIBILITY			
Guarantor / Payer			
Coverage Effective Date		**Participant's Relationship to Subscriber**	SELF
Subscriber's Policy #		**Subscriber's Medicaid #**	
MANAGED CARE AUTHORIZATION			
Guarantor / Payer		**Authorization Number**	

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Authorization Start Date:			**Authorization End Date:**		
Billed ID			**Participant ID**		
Service Codes (*choose all that applies*)			**Current Service at Home**		
☐	S5101	Basic Partial Per Diem (less than 3 hours)		**# of times / week**	
☐	S5101TG	Complex Partial Per Diem (less than 3 hours)	**Home maker**		
☐	S5102	Basic Adult Day Health Per Diem	**HHA / PCA**		
☐	S5102TG	Complex Adult Day Health Per Diem	**Nurse**		
☐	T2003	Adult Day Health Trans One Way	**Meals at home**		
			Rehab		
Type of Authorization					
Case Manager			**CM Phone:**		
Number of Days Approved			**M ☐ T☐ W☐ TH☐ F☐ Sat☐ Sun☐**		
ID Copy	☐		**All Insurance Card Copied**	☐	
Completed By:			**Date:**	**Phone:**	
Admitting Nurse:			**Date:**	**Phone:**	