

# LONG TERM CARE ADMINISTRATION COMMON INTAKE FORM

**Fax form to Long Term Care ADMINISTRATION: (405) 530-7265**

<b><u>Please Select a Program</u></b>
<input type="checkbox"/> Living Choice Demonstration Program

Personal Information				
Last Name	First Name	M.I.	Phone #	
SoonerCare ID	Date of Birth	Age	Sex	
Do you have a Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, Who? Name:		Phone #
Do you have a Medical Decision Making Power Of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, Who? Name:		Phone #

\*\* Please attach Guardianship Documentation with referral to be considered for The Living Choice Demonstration Program.

Institution Information				
Name of Institution where you now live			Room #	Provider ID #
Institution physical address	City	State OK	Zip	County
Institution director's name		Office Phone		
Personal physician's name	Admit Date	Length of stay in current facility:		

Person Making Referral:			
<input type="checkbox"/> Self	<input type="checkbox"/> Family Member	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Other
Name:		Agency/Relationship:	Phone #:
How did you hear about the Living Choice Project?			
<input type="checkbox"/> Self	<input type="checkbox"/> Family Member	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> MDS 3.0 <input type="checkbox"/> Other:

FOR OFFICIAL USE ONLY			
Date Received:	Date forwarded to OU PAT:	Eligibility Determination Date:	Assigned to: