



ALABAMA SENIOR_x

CLIENT INTAKE FORM

AIMS CLIENT NUMBER (office use)

Please complete and return to your Area Agency on Aging.
Call **1-800-AGE-LINE (1-800-243-5463)** for the correct mailing address.

Social Security #: _____ Medicare #: _____ County: _____		
Last Name: _____		First Name: _____ MI: _____
Mailing Address: _____ Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Other		
Street Address: _____ Birthdate: ____/____/____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
City/Zip: _____ Home Phone: (____) _____ - _____		
Did you file income taxes last year? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you a legal resident of Alabama? Yes <input type="checkbox"/> No <input type="checkbox"/>
Employment Status: <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Full time <input type="checkbox"/> Part time		Are you a veteran or veteran's spouse/widow? Yes <input type="checkbox"/> No <input type="checkbox"/>
Number living in household (including client): _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Not Married <input type="checkbox"/> Widowed		Spouse's Birthdate: ____/____/____
Spouse's Name: _____ Spouse's Social Security #: _____		
Primary Physician: _____		
Name	Address	Phone
Emergency Contact: _____		
Name	Phone	Relationship
SOURCES OF INCOME (We <u>MUST HAVE</u> a copy of proofs of income for EVERYONE who lives in your household.)		
TOTAL MONTHLY INCOME \$ _____		TOTAL ANNUAL INCOME \$ _____
Salary/Wages \$ _____	Unemployment \$ _____	Social Security Disability \$ _____
Veteran's Benefits \$ _____	Child Support \$ _____	Social Security \$ _____
Workman's Comp \$ _____	Pension \$ _____	SSI \$ _____
Railroad Retirement \$ _____	Interest Income \$ _____	Other \$ _____
(Attach copies of W2 forms, tax returns, bank statements, social security benefits statements, or other sources of income.)		
TOTAL AMOUNT OF ASSETS \$ _____		TOTAL MEDICAL EXPENSES \$ _____
For example: any bank accounts, investments, 401K, property you own (other than the house you live in)		(For example: Over-the-counter medicines, health insurance, premiums, copays, medical supplies, doctor & hospital visits, lab fees)
TOTAL AMOUNT OF EXPENSES \$ _____		PRESCRIPTION DRUG COSTS \$ _____
For example: mortgage or rent, utilities, insurance (not health insurance)		(a monthly average)

The Alabama Department of Senior Services, through 13 Area Agencies on Aging, administers this statewide program.
The information being collected will be kept **STRICTLY CONFIDENTIAL**

MEDICAL INFORMATION

Are you currently enrolled in another prescription assistance program or discount program? Yes No

Are you enrolled in Medicare VA Benefits SLMB QMB QI-1

Do you have any health insurance coverage? _____
 (other than Medicare) Company Policy #

Do you have a Medicare Supplemental Policy? _____
 Company Policy #

***If you have more than one prescribing physician, please attach a list with each doctor's name, address and telephone number. ALABAMA SENIOR RX cannot guarantee that you will receive the medicines requested.**

Medication	Directions/ Strength	Name, phone number and address of prescribing doctor	Cost per Month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical Conditions: (please circle) Heart Asthma High BP Ulcer Glaucoma

Other: _____

Medication Allergies: (please circle) None Sulfa Penicillin Aspirin Codeine Iodine

Other: _____

I hereby state that the information I have given is correct to the best of my knowledge and the **ALABAMA SENIOR RX** Program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand the **ALABAMA SENIOR RX** Program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services.

Signature: _____ Date: _____