OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Uniform Comprehensive Assessment, Part I
Intake and Referral

Numbers in parenthesis refer to item numbers in the Oklahoma Long-Term Care Authority (OLTCA) Manual.

Applicant information.

(1) **Indicate use of form**	(2) **Date completed (mo/day/year)**	(3) **Source of referral to this office List name, source, telephone - or - readmit**
Intake		
Screen and prioritization		
Comprehensive assessment		
Reassessment		
Referral out of this office		

Consumer information.

(4) Last name	First	MI	(8) Date of birth	
(5) Social Security number	Case number	Unique ID number	Area code	(9) Phone
(6) Street address	(7) City	State	Zip	

Additional sources of information.

(10) Last name	First	MI	Area code	(11) Phone
(12) Street address	City	State	Zip	

(13) Relation to consumer:

☐ Family, specify _____ ☐ Friend ☐ Hospital ☐ Other, specify _____

(14) Does the consumer know about this call or assessment interview? ☐ Yes ☐ No

(15) **(Ask)** What problems do you have right now that are causing you difficulty or what do you need assistance with? How long have you had these needs? What services are you receiving?

(Ask) What program or services are you requesting?

(16) Marital status: ☐ married ☐ divorced or separated ☐ widowed
☐ single, never married ☐ unknown

(17) **Consumer's residence.**

Household composition, for private residence consumers, is:

☐ private residence;
☐ residential care facility (RCF) or group home;
☐ nursing home; or
☐ other, specify _____

(18) **Consumer lives**:

☐ alone;
☐ with spouse;
☐ with children;
☐ with relatives;
☐ with friends; or
☐ other, specify _____

Number in household: _____

(19) Is the assistance of another person required for the consumer to leave home (homebound)? ☐ Yes ☐ No

Primary doctor:

(20) Primary doctor name	Area code	Phone
Address		

Other doctor:

Other doctor name	Area code	Phone
Address		

Legal guardian: ☐ Yes ☐ No Power of attorney: ☐ Yes ☐ No

(21) Name	Area code	Phone
Address	Relationship to consumer	

Emergency contact (someone outside the home):

(22) First emergency contact name	Area code	Phone
Address	Relationship to consumer	

Second emergency contact name	Area code	Phone
Address	Relationship to consumer	

(23) **Next of kin (nearest relative living in area):**

Name	Area code	Phone
Address	Relationship to consumer	
Name	Area code	Phone
Address	Relationship to consumer	

(24) **Consumer financial sources**	**Yes**	**Amount**
Earnings from employment, such as wages, salaries, income from your business	☐	$
Social Security. Include Social Security disability payments, but not SSI	☐	$
Veterans Affairs (VA) benefit such as G.I. Bill and disability payments	☐	$
Disability payments not covered by Social Security, SSI, or VA. Include both government and private disability payments and include Workers' Compensation.	☐	$
Retirement pension from job	☐	$
Money from children on a regular basis	☐	$
Interest or dividend income	☐	$
SSI payments (yellow government checks)	☐	$
Welfare payments: TANF	☐	$
Welfare payments: Food Stamps	☐	$
Other, specify	☐	$
TOTAL		
(25) Assets, excluding home and automobile	☐	$

(Ask) Have you or your spouse transferred, given, deeded, or sold any property in the past five years? ☐ Yes ☐ No

Do you have any checking accounts? ☐ Yes ☐ No

Amount: $_____ Total asset: $_____

(26) Are you a veteran or ever been a spouse of a veteran? ☐ Veteran ☐ Spouse ☐ Neither

(27) **Health insurance.**

Medicare - Part A	☐ Yes	☐ No	Medicare number: _____
Medicare - Part B	☐ Yes	☐ No	
SoonerCare (Medicaid)	☐ Yes	☐ No	Medicaid number: _____
VA	☐ Yes	☐ No	
Health maintenance organization (HMO)	☐ Yes	☐ No	
Indian Health Services	☐ Yes	☐ No	
Other health insurance	☐ Yes	specify: _____	
Don't know	☐ Yes		

(28) **Additional information.**

(29) What type of work did/do you do?

What grade did you complete in school?

(30) Gender: ☐ Female ☐ Male

(31) Race or ethnic background. **Read all categories before selecting answer.**

Do you consider yourself: ☐ White ☐ Hispanic
☐ Black/African American ☐ Asian or Pacific Islander
☐ Native American or Alaskan ☐ Other, specify: _____

(32) Are you a U.S. citizen or legal resident? ☐ Yes ☐ No
If no, country of origin: _____ Alien registration card number: _____

(33) Consumer's primary language: ☐ English ☐ Spanish ☐ Other, specify: _____
Does the consumer: speak English? ☐ Yes ☐ No
understand English? ☐ Yes ☐ No

Is consumer: ☐ deaf ☐ blind ☐ mute

If so, describe consumer's method of communication:

(34) **Referrals:**

Referral date mo/day/year	Services referred for	Agency referred to	Contact name

(35) Directions to consumer's location:

Completed by, print name	Agency	Area code	Phone

Additional comments and information.

The following actions were taken in response to the consumer's inquiry regarding in-home service provision:

- ☐ referral to Indigent Drug Program
- ☐ referral to Oklahoma Areawide Services Information System (OASIS)
- ☐ referral to Personal Care Program
- ☐ referral to the ADvantage Program
- ☐ advised of the availability of nursing facility care
- ☐ no action taken. Client does not want to apply for the ADvantage or Personal Care programs
- ☐ referral to Adult Protective Services
- ☐ provided information regarding other OKDHS programs
- ☐ referral to Area Agency on Aging (AAA)
- ☐ other referral, specify: _____

Notes:

_____ _____

Signature of person completing form Date

Date application received by OKDHS nurse: _____