

Volver A CASA

Home Health Services, Inc.

Provider Services

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☐ WAIVER ☐ NON-WAIVER ☐ PHC ☐ CAS ☐ FC

Individual Name: _____ Primary Language: ☐ English ☐ Spanish
Gender ☐ Male ☐ Female Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Single
Phone #: _____ Alternate Phone #: _____ Social Security #: _____ D.O.B. #: _____
Medicaid #: _____ Medicare #: _____
Physical Address: _____ City #: _____
Lives: ☐ alone or ☐ with someone Name and relationship: _____

Emergency Contact: _____ Relationship: _____
Address: _____ Phone #: _____
List Tasks: _____

Diagnosis: _____
Assistive device? ☐ Yes ☐ No List: _____
Hospital admissions last three months? ☐ Yes ☐ No

Hospital Name: _____ City / State: _____
Reason for hospitalization: _____
Date of Admission: _____ Date of Discharge: _____

Primary Physician Name: _____ Phone #: _____
Address: _____ City: _____

Dialysis Center? Facility: _____ Days/Hrs: _____ Phone #: _____
DAHS? Facility: _____ Days/Hrs: _____ Phone #: _____
Attendant of Choice: _____ Phone #: _____
Referred by whom: _____ Phone #: _____

Comments: _____

Verified individual status: ☐ Not Active ☐ Active Intake #: _____
DADS Intake Coordinator: _____ Date: _____

Signature of person completing form

Date