(1) Demographic Information
Candidate Name: ___________________________ Phone Number ________________ Gender ____ Date of Birth: _____________
Street Address ______________________ City ____________________ State ___________ Zip Code ___________ County ___________
Health Care Proxy___________________________________ Power of Attorney___________________________________
Personal Care Representative____

(2) Patient Activation Measure Assessment Level
PAM Assessment Completed: Yes ☐ No ☐ N/A ☐ PAM Level: 1 ☐ 2 ☐ 3 ☐ 4 ☐

(3) Medicaid/Commercial Eligibility Information	(4) Diagnostic Eligibility Information
Insurance Pending: ☐ Secondary Insurance:___________________________ Medicaid CIN:_____________________ Medicaid Managed Care Name if applicable:____________________________ Commercial Insurance:_____________________________	Chronic Condition 1:________________________ Chronic Condition 2: _______________________

(5) Risk Eligibility (Check all that apply)

Health Insurance and/or Financial Concerns	Transportation	Support Needs	Communication and/or Cultural Needs
☐ Lack of or no insurance coverage ☐ Need financial assistance from Medicaid ☐ Need for prescription assistance ☐ Need for medical equipment or supplies ☐ Need explanation of financial paperwork ☐ Difficulty paying bills ☐ Underinsured ☐ Other:_____________________________________	☐ Public transportation assistance needed ☐ Private transportation assistance needed ☐ Medicaid taxi transportation needed ☐ Volunteer transportation needed ☐Other:___________________	☐ Child/Elder Care ☐ Housing ☐ Food access ☐ Clothing ☐ Vocational support (i.e., job skill, employment skills) ☐ Extended care needs (i.e., home care, hospice, long-term care) ☐ Other:________________________________	☐ Primary language other than English ☐ Spanish ☐ Arabic ☐ Chinese ☐ Italian ☐ Other _______________ ☐ Inability to read/write ☐ Poor health literacy ☐ Other: _________________

(6) Documents

☐ Advanced Directives ☐ Cultural help completing a living will ☐ Needs a power of Attorney

☐ Health Care Proxy ☐ Other:____________________________________

(7) Referral Agency Information

Contact Name ______________________ Contact Number _________________ Does this Candidate have a Primary Care Physician? ☐ Yes ☐ No

Name Primary Care Physician and Facility______________________________________ Date of Last Visit with PCP_______________

What other Providers or Organizations is the patient currently working with? ____