Pathways, Inc.

we put people first

Recovery Coordination Intake Form

Date Form Completed:

Date of Last Eligibility Assessment:

Individual's Name:

Gender: Preferred Pronouns: DOB:

Race: Is the individual Hispanic/Latino? ☐Yes ☐ No

If yes, please clarify—(Cuban, Puerto Rican, etc.):

Primary Language: Interpretation Services Needed? ☐Yes ☐ No

Phone Number(s):

Preferred contact time:

Address:

Social Security #:

Medicaid # (Required): Medicaid Expiration Date (Required):

Managed Care Org:

Diagnoses:

1.

2.

3.

4.

Person Completing Form (Printed Name): Date:

Referring Provider Agency:

Referring Provider Agency Full Address:

Referring Provider Phone Number:

Pathways, Inc.