TOP AID
HEALTHCARE, INC

CLIENT – ADMISSION CHECK LIST

Referred by:_____Application Date_____Initials of AFC Staff:____
Client Name:_____D.O.B_____Caregiver Name:_____
Dr. Name:_____Phone:_____Fax:_____NPI:_____

Forms	Check if Received for File	Chart Audit Check If in Binder
Proof of Address		
Copy of MassHealth Card & MassHealth Insurance Verification Done		
Physician Summary Form/ Med List/ Problem List		
Client Referral Intake Form		
Client Data Sheet		
Medical Contact Information		
Photo Release Form		
Release Authorization Client/Caregiver/Alt		
Authorization for Release Medical Information		
Provider / Client Agreement for Services		
Authorization to Submit Medical Claims to MassHealth		
Placement Agreement		
HIPPA		
Notice of Privacy Info Acknowledgement		
Acknowledgement of Receipt of Privacy Info		
Provider Responsibilities		
Participants Rights and Responsibilities		
Program Participate Rights and Responsibilities		
Adult Psychosocial Assessment Done By: Date Done:		
MDS DONE Done By: Qualifying Level:	Date Done:	Aproval Date:
HOME ASSESSMENT DONE Done By: Approved:	Date Done:	

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