AccuKare, Inc.
Service Recipient Information Cover Sheet

Person Information

First name:	Last name:	Diagnosis Code:
Date of Birth:	Gender:	Start of Care:
Address:	Phone number:	Cell number:

Insurance Information

Primary insurance (if other than MA):	Medical Assistance number:
Member ID number:	Other insurance information:

Legal status

□ responsible for self □ under guardianship □ Minor □ under commitment

Legal representative contact information

First name:	Last name:
Address:	
Office number:	Cell number:

Responsible party for AccuKare services

□ self □ other

Responsible party contact information if other than self

First name:	Last name:
Address:	
Office number:	Cell number:

Primary emergency contact information

First name:	Last name:
Address:	
Office number:	Cell number:

All above information is to be considered confidential and is to be treated in accordance with agency policy.

Case Manager contact information

First name:	Last name:
Email: Fax number:	
Office number:	Cell number:

Health information

Medical history:
Special dietary needs:
Allergies:

Health care provider contact information

Primary physician name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

Health care provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:
Health care provider name:	
Clinic Name:	
Address:	
Phone number:	Fax number:

This program is responsible for assisting this person in setting up medical appointments : ☐ Yes ☐ No

All above information is to be considered confidential and is to be treated in accordance with agency policy.

Upon signature, I confirm the previous pages of my Service Recipient Information Cover Sheet are accurate and current to date.

Person or legal rep signature & date