AGED AND DISABLED WAIVER
CASE MANAGEMENT INITIAL CONTACT LOG

Last Name: _____ First Name: _____ MI: _____
Address: _____ DOB: _____

Applicant:

Case Management Agency: _____

Address: _____ Phone: _____ Fax: _____

Date Case Manager received notification from APS Healthcare/IRG of applicant selection: _____

Date of Initial contact: _____ (check one only) ☐ Face to Face ☐ Telephone

Case Manager Signature: _____ Date: _____ Time: _____

Date financial eligibility initiated: _____

Case Manager Signature: _____ Date: _____ Time: _____
**Note: Upload to ADW CareConnection©*

Comments:
_____
_____
_____
_____

ADW Participant:

Participant Enrollment Date: _____
Case Manager's Scheduled Home Visit Date: _____
Interim Service Plan Implemented? (Only for participants who need services immediately.)
☐ Yes
☐ No
Comments:
_____
_____
_____
_____
Case Manager Signature: _____ Date: _____ Time: _____

Seven (7) Day Contact:

Date direct care services began: _____
Date of Case Manager's follow up contact: _____
Comments:
_____
_____
_____
_____

Case Manager Signature: _____ Date: _____ Time: _____