Ceresti Empowerment Program Intake Form

Instructions: Please fill out this form for caregivers who are interested in participating in the Ceresti program. Send the completed forms via secure email to intakebcmn@ceresti.com.

BCBS Delegate Organization: _____

Care Coordinator Name: _____ **Care Coordinator Email:** _____

Member Name: _____ **Member Date of Birth:** _____

Member Residence (check one): ☐ **Home** ☐ **Assisted Living** ☐ **Memory Care** ☐ **Skilled Nursing** **Other:** _____

MA ID: _____

Is Member their own decision maker? (check one): ☐ **No** ☐ **Yes** **If yes, Ceresti has permission to contact Proxy?:** ☐

Caregiver Name: _____ **Relationship to Member:** _____

Caregiver Phone Number: _____ **Caregiver Address:** _____

Is Caregiver Proxy? (check one): ☐ **Yes** ☐ **No** **(If not, Provide Proxy Information Below)**

Proxy Name: _____ **Proxy Phone Number:** _____

Member Cognition (check one): ☐ **Normal** ☐ **Mild Impairment** ☐ **Moderate Impairment** ☐ **Severe Impairment**

Dementia Diagnosis (if known): _____

Member Current Chronic Conditions (Mark any that apply):

- ☐ Chronic Kidney Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Hypertension
- ☐ Parkinson's
- ☐ Severe Mental Illness (Bipolar,Schizophrenia)
- ☐ Stroke/Transient Ischemic Attack (Cerebral Vascular Disease)

Any Other Chronic Conditions not listed:

Member Relevant History in the Last 12 months for Falls, Substance Abuse, UTIs, ED Visits, Hospitalizations, or Skilled Nursing Stays (Note frequency, type, or length of stay, etc):

Other Notes (i.e. Social Determinants of Health, hospice care, living situation, current resources referred, or care gaps):