Revolve
Home Health

Community Access for People in Continuing Care (CAPCC) Participant Intake Form

Participant Information:

First Name: ______________________________ Last Name: _________________________________

Province: _________ Postal Code: ________ Room Number (if applicable): _________________________

Phone Number: ______________ Email address: ____

Date of Birth: _____________________ (YYYY/MM/DD)_______________Gender: ☐Male ☐Female

Emergency Contact / Guardian Information:

Full Name: ____

Relationship to Participant: ______________________________ Phone Number: _____________________

Email address: _____________________________

Referral Information:

Referral type: ☐ Self ☐ Family ☐ Continuing Care ☐ Alberta Supports ☐ Community Organization ☐ Other: _______

Referral Source Name/ Organization: __________________________ Date Referral: _______________________

Referred from Previous CAPCC Provider: ☐ Yes ☐ No

If Yes: Previous Provider Name: __________________________

Date Services Ended / Ending: ___________________________ (YYYY/MM/DD)

Baseline Needs & Support Profile

Mobility Status: ☐ Independent ☐ Requires Assistance ☐ Uses Mobility Aid ☐ Wheelchair
Cognitive / Communication Support: ☐ None ☐ Mild ☐ Moderate ☐ High
Comments: ______________________________________
Behavioral / Emotional Support Needs: ☐ None ☐ Mild ☐ Moderate ☐ High
Comments: ____

Medical Considerations (relevant only):
____
____
____

Allergies: ____

Current Supports & Services:
Current programs/services involved in: ____

Existing support network (family, staff, others): ____

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Interests/Preferences Activities:

____

____

Preferred Days/ Time for Activities: ____

Barriers to Participation:
☐ Financial ☐ Transportation ☐ Physical Accessibility ☐ Support Needs ☐ Other: ____________________

Transition & Continuity:
Transition from previous provider: ☐ Yes ☐ No
If yes:
Services to Continue Immediately: ____

Gaps or risks identified: ____
Priority Level: ☐ High ☐ Medium ☐ Low

Initial Support Needs Assessment:
Level of Support Required: ☐ Independent Participation ☐ Minimal Support ☐ Moderate Support ☐ 1:1 Support
Staffing Required: ☐ No ☐ Yes (Community Support Worker required)
Potential need for Revolve Staffing: ☐ Yes ☐ No

Transportation Needs: ☐ Independent ☐ Assisted ☐ Staff Escort

Preliminary Subsidy Indicator:
May require financial assistance to participate: ☐ Yes ☐ No
Barrier identified: ☐ Activity Fees ☐ Transportation ☐ Equipment ☐ Other: ____________________

Consent & Authorization

I hereby consent to:

- Participation in CAPCC services
- Collection and use of personal information for program delivery and reporting
- Sharing of relevant information with service providers as required

Referral/ Participant / Guardian Name: ______________________
Signature: ________________________________
Date: __________________________________

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Intake Completion
Intake Completed By: ________________________________
Position: ____
Date Completed: ___________________________________
Intake Outcome:

Eligibility Determination: (Office Use Only)
Participant resides in eligible continuing care settings: ☐ Type A Continuing Care ☐ Type B Continuing Care
☐ Other: _________________________
Age Requirements: ☐ Client meets the required age criteria .
Meets CAPCC Eligibility Criteria: ☐ Yes ☐ No
Eligibility Decision Date: ______________________________
Completed By: ______________________________________

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