



Accessing Any Baby Can Services is easy to do!

It is easy to qualify for assistance:

- ✧ Child between birth and 12 years of age
- ✧ Child lives in Bexar County or one of the surrounding 11 counties
- ✧ Child has chronic illness, developmental delay, health risk or challenge

All services are provided free of charge regardless of income.

How we can help you:

Skilled case managers can assist you navigate complex medical and social service programs. ABC can also help you with the following things:

- ✧ Completing applications for insurance and other assistance programs
- ✧ Payment of medications
- ✧ Payment of medical equipment
- ✧ Payment of rent, utilities, or other household costs
- ✧ Baby Supplies
- ✧ Other necessary items for families with a child with a special health care need

Get started now:

Complete the **Case Management Intake Form** if you have access to all of the information
OR

Complete the **Referral Form** and fax today.

Estella Garza, Intake Coordinator will contact family within 24 hours and officially open an Any Baby Can case. She will then assign the case to a case manager and schedule the initial face to face appointment ASAP to get started.



Print and Fax

Page 1 of 2

Intake Form

Date: _____

Last, _____ First _____ M _____

Client Name: _____

Address: _____ Gender: Male / Female

City: _____, Texas Zip Code: _____ County: _____

Ethnicity: _____ DOB: _____

Phone: () _____ Alternate Phone: () _____

Referral Source Name: _____

Purpose of Referral: _____

Secondary _____

Contact and Phone Number: _____

Mother's Name: _____

Address: _____ Phone: _____

City: _____, Texas Zip Code: _____

DOB: _____ Ethnicity: _____

Marital Status: _____ Language: _____

Occupation: _____ Work #: _____

Employment/School: _____ Ext. : _____

Education Level: _____ Military: Yes / No

Father's Name: _____

Address: _____ Phone: _____

City: _____, Texas Zip Code: _____

DOB: _____ Ethnicity: _____

Marital Status: _____ Language: _____

Occupation: _____ Work #: _____

Employment/School _____ Ext.: _____

Education Level: _____ Military: Yes / No

Guardian Name (when applicable): _____ Address: _____

Phone: _____ City: _____

_____, Texas Zip Code: _____ DOB: _____

Ethnicity: _____

Marital Status: _____ Language: _____

Occupation: _____ Work #: _____

Employment/School: _____ Ext.: _____

Education Level: _____ Military: Yes / No

HOUSEHOLD MEMBER INFORMATION

Total Household Members: _____

Name: _____ D O B: _____
 Relationship: _____ Gender: Male / Female Ethnicity: _____
 Marital Status: _____ Language: _____

Name: _____ D O B: _____
 Relationship: _____ Gender: Male / Female Ethnicity: _____
 Marital Status: _____ Language: _____

Name: _____ D O B: _____
 Relationship: _____ Gender: Male / Female Ethnicity: _____
 Marital Status: _____ Language: _____

** Please use attached form for additional family members.*

CLIENT INFORMATION

Medications: _____

Diagnosis: _____

Primary Care Doctor/Clinic: _____ Phone: _____

Specialists/Clinic: _____ Phone: _____

Specialists/Clinic: _____ Phone: _____

Specialists/Clinic: _____ Phone: _____

Other Providers: _____ Phone: _____

(Other Case Managers, Therapists, Counselors)

RESOURCES

<u>Income Sources:</u>	<u>Status</u>	<u>Mo. Amount</u>	<u>Programming:</u>	<u>Status:</u>	<u>Program #</u>	<u>Application Date</u>
Employment	FT-PT-Unemploy-Retired	\$ _____	CSHCN	Yes / No _____	_____	_____
TANF	Yes / No	\$ _____	Medicaid	Yes / No	Medicaid # _____	_____
SSI	Yes / No	\$ _____	Medicaid Plan	_____	_____	_____
FD Stamps	Yes / No	\$ _____				
Child Support	Yes / No	\$ _____	Pvt. Ins. Name & Number	_____	_____	_____
Other	Yes / No	\$ _____	CHIP	Yes / No	ChipRenewDate: _____	_____
Total Monthly Family Income		\$ _____	SKIP	Yes / No	SKIPRenewDate: _____	_____
Comments:			Early Childhood Education:	Yes / No		
			ECl:	Yes / No	Program Name: _____	
WIC	Yes / No	Clinic: _____				



Referral Form

Print and Fax

Date: _____

Child's Name: _____

DOB: _____ Age: _____ Preferred Language: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Insurance: _____

Diagnosis: _____

Reason for Referral/Need: _____

Person Making Referral: _____ Contact Number _____