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Non-Medical Intake Care Request Form

I am interested in having someone contact me regarding the care of:

Name of person requiring care: _____

Relationship: (Circle) **Self** ○ **Mother** ○ **Father** ○ **Spouse** ○ **Relative** ○
Relative (specify below) **Friend (specify below)**

[ ]

Address: _____
Street **City** **State** **Zip code**

Contact Person _____ _____ _____
Name **Home Phone No.** **Cell Phone No.**

Physician Info. _____ _____
Physician Name **Phone Number**

_____
Fax Number

Best Time To Call _____**Am / Pm**

With Which daily activities do you need assistance:

- ❑ Light Housekeeping
- ❑ Bathing
- ❑ Laundry & Linen Change
- ❑ Dressing & Oral Hygiene
- ❑ Meal Planning/Preparation
- ❑ Errands & Transportation
- ❑ Escort to Appointment
- ❑ Grocery Shopping
- ❑ Incontinence Care
- ❑ Medication Reminder
- ❑ Sitting/Companionship

What type of Insurance do you have?

- ☐ Medicare
- ☐ Medicaid
- ☐ Molina
- ☐ CareSource
- ☐ Humana
- ☐ Wellcare
- ☐ Private
- ☐ Aetna
- ☐ Athem Bluecross/Blueshield
- ☐ UniCare
- ☐ United Health One
- ☐ Other: _____