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: _____