CLIENT INTAKE FORM

CLIENT INFORMATION

Last Name: ________________________ First Name: ________________________ MI: ___

Gender: M F DOB: ____/____/____ SSN: __________________

Address: _________________________ City/State: ____________________ Zip: _________

Phone Number: ________________ Live Alone: ____Y ____N Primary Language: _______

Who is requesting services?

- o Individual seeking services
- o Family member / Caregiver
- o Waiver Support Coordinator
- o Facility / Referral Source

What are your schedule needs?

- o Weekdays (Morning Shift)
- o Weekdays (Mid Shift)
- o Weekdays (Overnight Shift)
- o Weekends (Morning Shift)
- o Weekends (Mid Shift)
- o Weekends (Overnight Shift)
- o Flexible

How will services be covered?

- o Private Pay
- o Medicaid
- o Other Insurance
- o Not Sure / In Process

Requested Services

- o Homemaker and Companion Services
- o Personal Support
- o Respite Care
- o Errands and Transportation
- o Medication Reminders
- o Other: ____

Please share any additional information or specific support needs.

Do you have any chronic conditions? ____Y ____N

Do you have mobility issues? ____Y ____N

If yes, please list mobility device used. ____

Are there any pets in the home? ____ Y ____ N

EMERGENCY CARE INFOMRATION

First Name: ___________________________ **Last Name:** ______________________________

Relationship to applicant: __________________________ **Phone:** _____________________

Address: ________________________ **City/State:** ______________________ **Zip:** _______

SECOND EMERGENCY CONTACT

First Name: ___________________________ **Last Name:** ______________________________

Relationship to applicant: __________________________ **Phone:** _____________________

Address: ________________________ **City/State:** ______________________ **Zip:** _______

NAME OF PHYSICIAN

First Name: _________________________ **Last Name:** _________________________

Phone Number: __________________________

HEALTH AND MEDICAL INFORMATION

Please list any medical conditions

Please list any current medications you are taking

Primary Diagnosis/Condition (if applicable):

Allergies:

INSURANCE INFORMATION

Insurance Carrier: ______________________ Insurance Plan: ______________________

Contact Number: _______________________ Policy Number: ________________________

Group Number _____________________ Social Security Number: ______________________

CONSENT & AUTHORIZATION

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE **REVAMP CARE LLC** TO PROVIDE NON-MEDICAL HOME CARE SERVICES AS AGREED UPON.

Parent or Guardian Name: ______________________ Relationship to Client: ____________

Signature of Client, Parent or Guardian: _________________________ Date: ____________