Client Application

. Client Information

- Full Name: _____
- Date of Birth: _____ Gender: Male/Female
- Address: _____

  _____
- Phone Number: _____
- Email Address: _____
- Preferred Language: _____ Marital Status: _____

Emergency Contact

- Name: _____
- Relationship to Client: _____
- Phone Number: _____
- Email Address: _____

Medical and Health Information

- Primary Care Physician Name: _____
- Phone Number: _____
- City, State: _____
- Medical Conditions and Diagnosis: _____
- Allergies: _____
- Current Medications: _____

  _____
- Special Dietary Needs or Restrictions: _____

  _____
- Mobility Status (Independent/Requires Assistance): _____

  _____

- Recent Hospitalizations or Surgeries (within the last 12 months): _____
  _____

- Do you require assistance with: (Bathing, Dressing, Eating, Toileting, Medication Management, Mobility/Transfers, Other)

  _____
  _____

Personal Care Preferences

- Preferred days and times for care services (e.g., Mon - Fri, 8am-4pm):

  _____
  _____

- Preferred Caregiver Gender: _____
- Cultural or Religious Considerations: _____
- Interests and Activities Enjoyed: _____
- Other Preferences or Special Requests: _____

  _____

Insurance and Payment Information

- Primary Insurance Holder Name: _____
- Primary Insurance Holder Date of Birth: _____
- Relationship to Client: _____
- Insurance Provider: _____
- Policy Number: _____
- Group Number (if applicable): _____
- Secondary Insurance Holder Name: _____
- Secondary Insurance Holder Date of Birth: _____
- Relationship to Client: _____
- Insurance Provider: _____
- Policy Number: _____
-

- Group Number (if applicable): _____
- Preferred Payment Method (Private Pay, Insurance, Medicaid/Medicare, Other:)

_____

Legal and Consent Information

- Do you have an Advanced Healthcare Directive? (If yes, please attach a copy to this form):
  _____
  Power of Attorney or Legal Guardian Name: _____
- Relationship to Client: _____
  Phone Number: _____
- Address: _____
-
-

  _____
  Emergency Medical Consent (By signing, you consent to receive emergency medical
- treatment if needed):
  _____

Additional Information

- Please provide any additional information that would help us deliver the most personalized care here:
  _____
  _____

Acknowledgement and Signature By signing below, I certify that the information on this form is accurate and complete to the best of my knowledge. I understand that providing false information can result in the termination of services

- Client or Responsible Party Name: _____
  Relationship to Client (if applicable): [e.g., Legal Guardian, Caregiver, etc.]
-

  _____
  Date: _____
-