

Intake Date: _____

Client Information

Clients Name: _____ Age _____

Client Address: _____

City/State/Zip Code: _____

Phone _____

Caregiver Information

Name: _____

Address: _____

City/State/Zip Code: _____

Phone _____

PROPOSED SCHEDULE:

Start Date _____ Day(s) of Wk. Monday | Tuesday | Wednesday | Thursday | Friday | Transportation - Roundtrip -YES - NO

Number of Days: _____

Proposed Funding: Private Pay / LTC /

Personal Checks, Visa, Mastercard, Zelle payment to info@goldencircleoffriends.com

Checks payable to Golden Circle Of Friends.

Cancellation within 2 hours of rides or you may be charged:

Circle Payment Option – Payment is due in advance of all rides:

Payment Option – Weekly, Bi-weekly, Monthly

Living Arrangements:

Lives Alone With Family Senior Housing.

Please ANSWER YES or NO to the following:

Covid vaccine fully vaccinated YES or NO (All applicants must be fully vaccinated)*

Catheter Oxygen? **YES or NO** Fall risk **YES or NO**

Vision Problems **YES or NO** Mobility devices | Cane, Walker, Wheelchair **YES or**

NO. Applicants must be able to get in and out wheelchair with assistance*

Behavioral Needs: Aggression and/or Combativeness? **YES or NO**, Verbal

Inappropriateness? **YES or NO**, Wanders? **YES or NO** Dementia **YES or NO**

Non-Verbal YES or NO

Emergency Contact Information: (1)

Name _____ Relationship: _____

Phone Number: _____

Emergency Contact Information (2)

Name: _____ Relationship: _____

Phone Number: _____

Email – info@goldencircleoffriends.com

Fax 630 – 596- 1070