Contact information

* Indicates required question

1. Email *

2. **Your Full Name** *

3. **Your Telephone Number** *

4. Your Email Address *

5. **Patient'S Full Name**

6. **Patient Telephone Number** ***(if applicable)***

7. **Relationship to Patient** *

Mark only one oval.

- ◯ Self
- ◯ Family Member
- ◯ Case Manager
- ◯ Guardian
- ◯ Other

8. **Living Ability -Is this patient able to live independently?** *

Mark only one oval.

- ◯ Yes, fully independent
- ◯ Some assistance needed
- ◯ Requires adult foster care
- ◯ Not Sure

9. **Does the patient require assistance with daily living (ADL)** *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Medication reminders
- ◯ Meal prepartion
- ◯ Transportion
- ◯ Personal Care
- ◯ Other

10. **Monthly Income Range**

Mark only one oval.

- Less than $1,000
- $1,000 - $2,000
- $2,000 - $3,000
- $3,000+

11. **Source of Income** *

Mark only one oval.

- SSI
- SSDI
- Employment
- Retirement
- None/Other

12. **Move -in Timeline** -*How soon is the patient able to move?* *

Mark only one oval.

- Immediately
- Within 30 days
- 1-3 months
- 3+ months

13. **Do you have any additional information we should know?**

14. **Consent & Acknowledgment** *

Check all that apply.

☐ I confirm the information provied is accurate and authorize KMN Adult Foster Care Independent Living to contact me regarding placement options.