A1 Residential Care Facility

24-Hour Safe-Stay Trial Pre-Screen / Intake Form

Please complete this quick intake form so we can best assist your family and ensure your loved one's needs are met during the 24-hour trial. All information is confidential.

Resident Name: _____

Date of Birth: ____ / ____ / _____

Responsible Party / Contact: _____

Phone: _____

Email: _____

Relationship to Resident: _____

Desired Trial Date: ____ / ____ / _____

Desired Move-In Timeline: Immediate / 1 Month / 2–3 Months / Future

Monthly Budget for Care (range): $_____ – $_____

Benefits (check all that apply): ■ VA ■ Medi-Cal ■ Long-Term Care Insurance ■ Private Pay

Additional Notes / Special Needs: _____

Signature of Responsible Party: _____
Date: _____