GUARDIAN
PERSONAL CARE SERVICES, LLC

Client Intake Application

Client Name: _____

Social Security Number: _____ Date of Birth: _____

Gender: Male ___ Female ___ Ethnicity: _____

Address _____

Phone: _____ Alternate Phone: _____

Primary Language Spoken: _____

Payment Type: Medicaid _____ Private Insurance _____ Private Pay _____

Emergency Contact: _____ Phone: _____

Do you have your own Caregiver you would like to provide cares to you? ___Yes ___ No

If yes, what is the name of your Caregiver? _____

What is your Caregiver's relationship to you? _____

If you are requesting Supportive Home Care Services, complete this section:

What do you need help with? (**Please Check All That Apply**)

__ Dishes/Clean up __ Laundry __ Linen Changes __ Dust/General Cleaning

__ Meal Prep/Serve - Breakfast __ Meal Prep/Serve - Lunch __ Meal Prep/Serve - Dinner

__ Grocery shopping __ Floor Care/Sweep/Mop/Vacuum

If you are requesting Personal Care Services alone or in addition to Supportive Home Care Services, complete the rest of this form:

What do you need help with? (**Please Check All That Apply**)

__ Dressing/Undressing __ Meals/Cooking/Eating __ Skin Care __ Nail Care

__ Hair Care __ Bathing __ Shaving __ Oral Hygiene

__ Transfers (Bed/Chair) __ Splints/Braces __ Mobility (Walker, Cane, Etc.)

__ Bathroom Assistance (Toileting) __ Incontinence Care

__ Medication Assistance/Medication Reminders

What is your diagnosis or condition? (**Please Check All That Apply**)

__ Diabetes __ High Blood Pressure __ Dementia __ Legally Blind __ Arthritis __ Dialysis

__ Congestive Heart Failure __ Hearing Impairment __ Stroke __ Cancer __ Paralysis

__ Bowel/Bladder (Incontinence) __ Fibromyalgia __ Other (Please Specify: _____)

Primary Care Physician:

Name_____ Phone _____ Fax _____

Address _____

Is your Primary Care Physician the doctor who we should contact to get orders for you to have an assessment for personal care services? __ Yes __ No

If no, what is the name of the doctor we should contact?

Name_____ Phone _____ Fax _____

Address_____

Is there a person authorized to represent you and sign all forms on your behalf? If yes, complete below.

Name _____ Relationship _____ Phone _____

Address _____

Should all correspondence be sent to this person? __ Yes __ No

The above information is true and correct to the best of my knowledge.

Signature of Client/Client's Representative _____ Date_____

When the application is completed, please send back to Guardian Personal Care Services, LLC.

GUARDIAN PERSONAL CARE SERVICES, LLC
4788 N 126TH ST BUTLER, WI 53007
PHONE: (262) 395-4568 FAX: (262) 395-4576