Home Care

Client Intake Form

*Financial Information*

# PAYMENT MENTHOD CHECK IF APPLICABLE

PRIVATE PAY: ☐

INSURANCE: ☐

MEDICAID/MEDICARE: ☐

OTHER: ☐

# INSURANCE PROVIDER: POLICY NUMBER:

**GROUP NUMBER:**

# PRIMARY POLICYHOLDER NAME:

*Consent & Agreement*

BY SIGNING BELOW, I CONSENT TO THE CARE SERVICES PROVIDED BY THE AGENCY AND CONFIRM THAT THE INFORMATION PROVIDED IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

CLIENT/RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIS FORM PROVIDES A STRUCTURED AND DETAILED WAY TO COLLECT ALL ESSENTIAL INFORMATION DURING THE CLIENT INTAKE PROCESS, WITH CLEAR SECTIONS AND TABLES TO ENHANCE CLARITY AND ORGANIZATION.