IN HOME CARE PROVIDERS LLC

IHCP

1501 Main Street, Suite 501, Columbia, SC 29201

Office: (803) 683-3911

New Client Caregiver Plan & Needs Assessment Application

SECTION 1: CLIENT INFORMATION

- Client Full Name:_____

- Date of Birth:_____

- SSN (last 4 digits):_____

- Address: _____

- Phone Number:_____

- Emergency Contact Name & Phone:

1)_____

2)_____

3)_____

Primary Physician Name & Phone**:**

_____

SECTION 2: INSURANCE & FUNDING

-Private Insurance

Name & Member ID# (if any):_____

- Medicaid ID #:_____

- Medicare ID #:_____

- Payer Source: [ ] Medicaid Waiver [ ] Private Pay [ ] Veterans Services [ ]

Other:_____

SECTION 3: LIVING SITUATION & ENVIRONMENT

- Client lives: [ ] Alone [ ] With family [ ] With caregiver [ ] Assisted living -

Type of residence: [ ] House [ ] Apartment [ ] Mobile Home [ ] Other: -

Any safety hazards

noted:_____

_____

_____

_____

SECTION 4: CLIENT NEEDS ASSESSMENT

- [ ] Bathing Assistance
- [ ] Dressing
- [ ] Grooming
- [ ] Oral Hygiene
- [ ] Toileting
- [ ] Ambulation
- [ ] Medication Reminders
- [ ] Feeding
- [ ] Vital Signs Monitoring
- [ ] Light Housekeeping
- [ ] Laundry
- [ ] Meal Preparation
- [ ] Grocery Shopping
- [ ] Transportation
- Additional Notes:_____

_____

_____

SECTION 5: COGNITIVE / MENTAL STATUS

- [ ] Oriented
- [ ] Memory Impairment
- [ ] Supervision Required
- [ ] Dementia
- [ ] Depression/Anxiety
- Behavioral Concerns:_____

_____

_____

_____

_____

SECTION 6: MEDICAL INFORMATION

- Diagnoses:
- Allergies:
- Assistive Devices: [ ] Walker [ ] Cane [ ] Wheelchair [ ] Oxygen [ ] Hearing Aid [ ] Glasses [ ]

Other:_____

Medications:_____

_____

_____

_____

_____

SECTION 7: CLIENT PREFERENCES

- Preferred Schedule: [ ] Morning [ ] Afternoon [ ] Evening [ ] Overnight
- Days: [ ] M [ ] T [ ] W [ ] Th [ ] F [ ] Sat [ ] Sun
- Preferred Language:
- Cultural or Religious Considerations:_____

_____

_____

SECTION 8: SERVICE PLAN GOALS

Please describe the primary goals for care: _____

_____

_____

SECTION 9: AUTHORIZATIONS & SIGNATURES

I certify the above information is accurate to the best of my knowledge... Client / Authorized Rep Signature: _____ Date: _____

In Home Care Providers LLC Rep Name/Title: _____

Signature: _____ Date: _____