Part 1 — Patient Identification

Please complete all fields marked with an asterisk (*). This information is used solely to coordinate your care and is kept strictly confidential in accordance with HIPAA.

First Name *

Last Name *

Date of Birth (MM / DD / YYYY) *

Gender (Circle: Male / Female / Non-binary / Prefer not to say)

Home Address (Street, City, State, ZIP) *

Primary Phone Number *

Alternate Phone Number

Email Address

Social Security Number (last 4 digits)

Preferred Language / Communication Needs

Insurance Provider / Payer Name

Please attach a copy of the front and back of your insurance card if available.

Insurance Member ID

Insurance Group Number

Medi-Cal / Medicare Number (if applicable)

Authorization Number (if pre-approved)

Part 2 — Level of Care Assessment

This section helps us understand the client's current needs and match them with the most appropriate level of non-medical home care. All information is treated with the utmost sensitivity.

Date of Referral *

Referral Received Date

Initial Contact Date

Requested Start Date *

Primary Reason for Requesting Care *

Describe the client's primary condition, recent changes in health status, or circumstances prompting the request for care.

Current Medical Diagnoses / Relevant Health History

Include any diagnoses shared by the referring physician or family. Non-medical staff will not interpret or assess this information.

Activities of Daily Living (ADLs) Requiring Support — Check all that apply:

[ ] Bathing & Personal Hygiene
[ ] Dressing & Grooming
[ ] Toileting & Incontinence Care
[ ] Mobility & Transfers
[ ] Feeding & Meal Preparation
[ ] Medication Reminders
[ ] Light Housekeeping
[ ] Laundry & Linen Changes
[ ] Grocery Shopping & Errands
[ ] Transportation to Appointments
[ ] Companionship & Socialization
[ ] Respite Care for Family

Other Care Needs Not Listed Above

Requested Care Schedule:

[ ] Live-In Care (24 hours)
[ ] Daytime Hours (8 am – 5 pm)
[ ] Evening Hours (5 pm – 10 pm)
[ ] Overnight (10 pm – 8 am)
[ ] Weekends Only
[ ] As-Needed / Flexible

Estimated Hours Needed per Week

Anticipated Duration of Care

Mobility & Safety Considerations — Check all that apply:

[ ] Uses Wheelchair
[ ] Uses Walker / Cane
[ ] Fall Risk
[ ] Cognitive Impairment / Memory Issues
[ ] Behavioral Considerations
[ ] Hospice or Palliative Setting

Additional Notes on Safety or Special Instructions

Include any known allergies, behavioral triggers, preferred routines, or specific caregiver preferences.

Part 3 — Primary Caregiver & Emergency Contact

Please provide the contact details of the person responsible for coordinating the client's care and the designated emergency contact. Both individuals will be kept informed of any significant changes to the care plan.

Primary Caregiver / Responsible Party

Caregiver First Name *

Caregiver Last Name *

Relationship to Client *

Primary Phone Number *

Email Address

Alternate Phone Number

Home / Mailing Address (if different from client)

Preferred Contact Method:

[ ] Phone Call [ ] Text Message [ ] Email [ ] Any of the above

Best Time to Reach:

[ ] Morning (8 am – 12 pm) [ ] Afternoon (12 pm – 5 pm) [ ] Evening (5 pm – 8 pm)

Emergency Contact (if different from above)

Emergency Contact Full Name * | Relationship to Client *

Primary Phone Number * | Alternate Phone Number

Email Address

Referring Agency / Physician (if applicable)

Referring Agency / Physician Name | Contact Person at Agency

Phone Number | Fax Number

Email Address

Authorization & Acknowledgement

By signing below, I confirm that the information provided is accurate to the best of my knowledge. I authorize E & L Compassionate Care LLC to use this information for the purpose of coordinating and delivering home care services. I understand that my personal information will be kept confidential in accordance with applicable privacy laws.

Client / Authorized Representative Signature | Date

Printed Name | Title / Role (if completing on behalf of client)

FOR OFFICE USE ONLY

Intake Coordinator	Date Received	Case ID / Client #	Assigned Care Manager

Service Start Date (Confirmed)	Referral Source