Connecticut Caregiver Connection

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Client Intake Form

Personal Information (of client's representative)

Referred to by:

Name (full name):

Phone Number(s): Cell:

Relationship to client: ***please check a box***

POA ☐ (must provide documentation)

Conservator ☐ (must provide documentation)

Family ☐

Friend ☐

Patient Information

Clients Name: _____

Home address: _____

Directions:

_____

_____

Phone Number: _____

Client's DOB: _____

Plan of Care:

Please check all boxes the client needs help with and anything additional please add.

- □ Bathing/ Showering
- □ Transfers
- □ Companionship/ Monitor Safety
- □ Toileting
- □ Ambulation
- □ Meal preparation
- □ Medication reminders
- □ Light housekeeping
- □ Transportation

□ Grooming/ Oral hygiene

□ Physical therapy exercises (aides should be trained by the Physical Therapist)

□ Special dietary needs: _____

_____

_____

_____

Specific Instructions for Plan of care:

_____

_____

_____

_____

_____

Are there any pets in the home? Yes ☐ No ☐

If yes how many and how large: _____

Are there any smokers in the home? Yes ☐ No ☐

Days Service Needed (check all that apply):

	Su	M	Tu	W	Th	F	S
	☐	☐	☐	☐	☐	☐	☐
Start Time	____:____	____:____	____:____	____:____	____:____	____:____	____:____
End Time:	____:____	____:____	____:____	____:____	____:____	____:____	____:____
Live-IN:	☐	☐	☐	☐	☐	☐	☐

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Start Date: _____

End Date: _____ (***Only fill out if the case is not on going)***

Payer Information

Payer's full name: _____

Payer Address: _____

City/State/Zip: _____

Payer Phone Number: _____ Cell:_____

Long term Care Insurance Policy

Long term Insurance Company: _____

Policy Number: _____

Submit Form

Reset Form

Print Form