Healing House
Your mind is your healing house

Date:

Non-Medical Respite/Companion Care Inquiry Form

POTENTIAL MEMBER NAME:			**DOB:**
ADDRESS:			**PHONE:**
CITY:		**ZIP:**	**COUNTY:**
ETHNICITY:			
LIVES (circle one):	ALONE	WITH SPOUSE	WITH CAREGIVER
OTHER (please specify):			
CAREGIVER'S NAME:			**PHONE:**
			EMAIL:

Basic Description of services needed (please explain):

Physical/Medical Condition of Potential Member (please explain):

FUNCTIONS OF DAILY LIVING CHECKLIST

MOBILITY NEEDS (circle all that apply): Cane—Brace—Wheelchair—Walk unaided—Other (specify):
MEALTIME NEEDS (circle all that apply): Fix meals—Cannot Fix meals—Want help with meals—Can feed self— Cannot feed self— Other(specify):
PERSONAL CARE NEEDS (circle all that apply): Can bathe self— Cannot bathe self—Can groom self— Cannot groom self— Can dress self— Cannot dress self— Other (specify):
SLEEP PATTERNS: Wanders—Sleep all night— Take naps— Other (specify):

Mental Condition of Potential Member (circle all that apply):

Alert—Mildly confused— Extremely confused— Short term memory loss— Long term memory loss— Recognizes caregiver— Recognizes others—Poor recognition— Understands speech— cannot understand speech—Can speak— Cannot Speak— Other (specify):

Behavioral Health/Mental Health diagnosis (Specify)

How often is none-medical respite/companion services desired (please specify days and times and if only on-call services are being requested at this time)

Comments or Concerns:

***Please Note:** a member of our team will look over this inquiry and contact caregiver or potential member with 48 hours, regarding an intake and care plan meeting.

Thank You for choosing us!

OFFICE STAFF USE ONLY

Received by:

Date:

Inquiry Accepted— — — **Inquiry Denied— —-**