



Child and Family Services

SENIOR COMPANION PROGRAM

INTAKE FORM

DATE OF INTAKE: _____

STATION REFERRED TO: _____

ADDRESS: _____

NAME OF CONTACT PERSON: _____

CLIENT INFORMATION

Clients Name: _____ Date of Birth: _____

Client Address: _____

City/State/Zip Code: _____ Phone Number: _____

EMERGENCY CONTACT PERSON

Name: _____ Relationship: _____

Phone Number: _____

CLIENTS PROBLEMS/NEEDS:

Living Arrangements:

- Lives Alone
- With Family
- Nursing Home
- Senior Housing
- Homeless

Physical Problems: _____

Hearing/Speech: _____ Current Nurses Aide/Therapist Yes No

Requested # of Days _____ # of Hours _____

The potential client states he/she is facing Nursing Home Placement: Yes No

AGENCY:

Agency making referral: _____ Person making referral: _____

Title: _____ Phone Number: _____

