Client Intake Form

[AGENCY NAME] · [OFFICE PHONE]

REFERRAL INFORMATION

Date of Referral	**Taken By**
Referral Source	**Referral Contact & Phone**

CLIENT INFORMATION

Client Full Name	**Date of Birth**
Address	**City / State / ZIP**
Phone	**Email**
Primary Language	**Lives Alone?** ☐ Yes ☐ No

EMERGENCY CONTACT / REPRESENTATIVE

Name	**Relationship**
Phone	**Legal Representative?** ☐ Yes ☐ No

PAYER

☐ Medicaid / Waiver ☐ Private Pay ☐ Long-Term Care Insurance

☐ Veterans Program ☐ Other:

Member / Policy ID	**Authorization # / Hours**

SERVICES REQUESTED

☐ Bathing ☐ Dressing / Grooming ☐ Toileting

☐ Transfers / Mobility ☐ Meal Preparation ☐ Light Housekeeping

☐ Laundry ☐ Errands / Shopping ☐ Companionship

☐ Medication Reminders ☐ Respite ☐ Other:

Days / Hours Requested	**Requested Start Date**

INTAKE DECISION

☐ Accepted, assessment scheduled for: _____ ☐ Not accepted, reason / referred to: _____

_____ _____

Intake Staff Signature Date

Referral Log

[AGENCY NAME] · [OFFICE PHONE]

Date	Client Name	Referral Source	Payer	Services	Accepted? Y/N	Assessment Date	Staff

Initial Assessment

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Date of Assessment
Assessed By	Location

HEALTH INFORMATION

Primary Physician & Phone	Diagnoses (as reported)
Allergies	Diet / Restrictions

☐ Hearing difficulty ☐ Vision difficulty ☐ Memory problems ☐ History of falls ☐ Uses oxygen ☐ Smoker in home

DAILY LIVING NEEDS (I = INDEPENDENT, A = NEEDS SOME HELP, D = DEPENDENT)

Activity	I	A	D	Notes
Bathing				
Dressing				
Grooming				
Toileting / Continence				
Transfers				
Walking / Mobility				
Eating				
Meal Preparation				
Housekeeping				
Laundry				
Shopping / Errands				
Medication Reminders				

MOBILITY EQUIPMENT

☐ Cane ☐ Walker ☐ Wheelchair ☐ Gait Belt
☐ Shower Chair ☐ Grab Bars ☐ Hospital Bed ☐ Other:

PREFERENCES, ROUTINES AND GOALS

Assessor Signature

Date

Home Safety Checklist

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Date
Completed By	Address

Item	Yes	No	Notes / Action Needed
Working smoke detectors	☐	☐	
Carbon monoxide detector (if gas appliances)	☐	☐	
Fire extinguisher available	☐	☐	
Walkways and stairs clear of clutter	☐	☐	
Rugs secured or removed	☐	☐	
Adequate lighting, including night lights	☐	☐	
Grab bars in bathroom	☐	☐	
Non-slip mat in tub or shower	☐	☐	
Stair handrails secure	☐	☐	
Emergency numbers posted by phone	☐	☐	
Medications stored safely	☐	☐	
Pets secured during visits	☐	☐	
Firearms locked and stored away	☐	☐	
No smoking during visits / oxygen safety followed	☐	☐	
Working phone in the home	☐	☐	
Home free of pests and hazards to staff	☐	☐	

CONCERNS DISCUSSED AND PLAN

Client or Representative Signature

Date

Agency Representative Signature

Date

Client Welcome and Service Agreement

[AGENCY NAME] · [OFFICE PHONE]

This agreement is between [AGENCY NAME] ("the Agency") and the client named below. It describes the services the Agency will provide and the terms both parties agree to.

Client Name	**Start Date**
Representative (if any)	**Relationship**

SERVICES AND SCHEDULE

Services	**Days / Times**
Hours per Week	**Payer**

RATES AND PAYMENT

Hourly Rate	**Minimum Hours per Visit**
Weekend / Holiday Rate	**Mileage Rate (errands)**
Billing Frequency	**Payment Due**

TERMS

- The Agency provides non-medical services only. Caregivers do not give medications, do wound care or perform other skilled nursing tasks.
- Please give at least [CANCELLATION NOTICE HOURS] hours' notice to cancel a visit. Late cancellations may be billed at [LATE CANCELLATION FEE].
- Caregivers may not accept gifts, money or loans, and may not work for the client privately outside the Agency.
- Rates may change with at least [RATE CHANGE NOTICE DAYS] days' written notice.
- Either party may end this agreement with [DISCHARGE NOTICE DAYS] days' written notice, except in an emergency involving safety.
- The client has received the Client Bill of Rights, complaint process and emergency information.

Client or Representative Signature _____ Date _____

Agency Representative Signature _____ Date _____

Consent to Services

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Date of Birth

I agree to receive non-medical home care services from [AGENCY NAME] as described in my plan of care. I understand that:

- I may refuse any service or end services at any time.
- The Agency will share my information only as needed to provide my care, to bill for services, or as the law requires.
- Caregivers will check in and out of visits electronically where required.
- In an emergency, the Agency or caregiver will call 911 and then my emergency contact.
- I may ask questions about my care or file a complaint at any time without losing services.

INITIAL EACH ITEM

Consent	Initials
I consent to receive services.	
I consent to the Agency contacting my emergency contact and physician as needed.	
I consent to photographs only for identification in my record (optional).	
I received a copy of my plan of care.	

Client or Representative Signature

Date

Agency Representative Signature

Date

Client Bill of Rights and Acknowledgment

[AGENCY NAME] · [OFFICE PHONE]

As a client of [AGENCY NAME], you have the right to:

- Be treated with courtesy, dignity and respect.
- Take part in planning your care and be told about changes in advance.
- Refuse services and be told what may happen if you do.
- Privacy and confidentiality of your information and records.
- Know the cost of services, in writing, before they begin.
- Be free from abuse, neglect, exploitation and discrimination.
- Have your property and home treated with respect.
- Voice complaints without fear of losing services or being treated differently.
- Receive services from trained and qualified staff.

You are responsible for:

- Giving accurate and complete information about your needs.
- Telling the Agency about changes in your health, address or needs.
- Providing a safe place for caregivers to work.
- Treating caregivers with respect.
- Paying for services as agreed.

HOW TO MAKE A COMPLAINT

Call [OFFICE PHONE] or write to [AGENCY ADDRESS]. We will respond within 10 business days. You may also contact [STATE LICENSING AGENCY]. To report abuse, neglect or exploitation, call [ABUSE HOTLINE NUMBER].

I received and understand this Bill of Rights.

Client or Representative Signature

Date

Agency Representative Signature

Date

Authorization to Release Information

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Date of Birth

I authorize [AGENCY NAME] to:

☐ Release information to ☐ Obtain information from

Name / Organization	Address
Phone	**Fax / Email**

INFORMATION TO BE SHARED

☐ Plan of care
☐ Assessment
☐ Entire record
☐ Visit records
☐ Incident reports
☐ Other:

Purpose of Release	This Authorization Expires On

I understand I may cancel this authorization in writing at any time, except for information already released. My services do not depend on signing this form. Information released may be re-disclosed by the recipient and no longer protected by federal privacy law.

Client or Representative Signature _____ Date _____

Agency Representative Signature _____ Date _____

Plan of Care

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Start Date	Prepared By	Next Review Date
Emergency Contact & Phone	Physician & Phone	Allergies	Diet

VISIT SCHEDULE

Day	Time In	Time Out	Hours	Notes
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

TASKS

Task	How Often	Special Instructions
Bathing		
Dressing / Grooming		
Toileting		
Transfers / Walking		
Meal Preparation		
Light Housekeeping		
Laundry		
Medication Reminders		
Errands / Companionship		

SAFETY CONCERNS AND CLIENT PREFERENCES

Client or Representative Signature

Date

Agency Representative Signature

Date

Caregiver Timesheet and Task Log

[AGENCY NAME] · [OFFICE PHONE]

Caregiver Name	Client Name	Week Of	EVV Used? ☐ Yes ☐ No

Day / Date	Time In	Time Out	Hours	Bath	Dress	Toilet	Meals	House-keep	Laundry	Errands	Client Changes / Notes	Client Initials
Sun												
Mon												
Tue												
Wed												
Thu												
Fri												
Sat												

I certify that the times and tasks above are true and correct. Falsifying time records is grounds for termination and may be reported as fraud.

Caregiver Signature _____ Date _____

Client or Representative Signature _____ Date _____

Missed Visit Log

[AGENCY NAME] · [OFFICE PHONE]

Date	Client	Scheduled Caregiver	Reason	Covered By / Not Covered	Client Notified (time)	Staff

Errand and Purchase Log

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Caregiver Name	Month	Mileage Rate

Date	Errand / Store	Money Received	Amount Spent	Change Returned	Receipt? Y/N	Miles	Caregiver Initials	Client Initials

Discharge Summary

[AGENCY NAME] · [OFFICE PHONE]

Client Name	Start of Services
Discharge Date	Completed By

REASON FOR DISCHARGE

- ☐ Client request
- ☐ Moved out of service area
- ☐ Payer ended / non-payment
- ☐ Unsafe environment
- ☐ Other:
- ☐ Goals met
- ☐ Admitted to facility
- ☐ Needs beyond agency services
- ☐ Client deceased

Written Notice Given On	Referred To

SUMMARY OF SERVICES AND CLIENT STATUS AT DISCHARGE

Staff Signature

Date

Background Check Authorization

[AGENCY NAME] · [OFFICE PHONE]

Full Legal Name	Other Names Used
Date of Birth	Driver License / ID # and State
Current Address	Addresses in Past 7 Years

I authorize [AGENCY NAME] and its background check provider to obtain criminal history, registry and other records as required for employment or contracting in home care, including: [BACKGROUND CHECK TYPE]. I understand that I may not have client contact until all required checks are complete, and that false or missing information may disqualify me.

You have the right to request a copy of any report obtained and a summary of your rights under the Fair Credit Reporting Act.

Applicant Signature

Date

New Hire Checklist

[AGENCY NAME] · [OFFICE PHONE]

Worker Name	Position
Hire Date	Completed By

Item	Date Done	Initials
Application		
Interview notes		
References checked (2)		
Background check authorization signed		
Background and registry checks cleared		
Exclusion list check		
Photo ID copied		
Form I-9 (kept separately)		
Tax forms		
Certifications / license copied		
TB screening or health statement (if required)		
Driver license and auto insurance (if driving)		
Signed job description		
Signed confidentiality agreement		
Orientation completed		
Initial training completed		
Skills competency check completed		
ID badge issued		
EVV / scheduling app set up		

Staff Confidentiality Agreement

[AGENCY NAME] · [OFFICE PHONE]

As a worker of [AGENCY NAME], I will see private information about clients, their families and the agency. I agree that:

- I will use client information only to do my job, and share it only with people who need it for the client's care.
- I will not discuss clients in public places or with my family and friends.
- I will not post anything about clients on social media, including photos, names, locations or details.
- I will not take photos or videos of clients or their homes unless the agency directs me to.
- I will keep agency passwords private and lock any device that holds client information.
- I will report any lost device or improper sharing of information to the office right away.
- I will not copy or share agency forms, training materials or documents with anyone outside the agency.
- These duties continue after I stop working for the agency.

I understand that breaking this agreement may lead to discipline up to termination and may violate federal and state law.

Worker Signature

Date

Agency Representative Signature

Date

Orientation Checklist

[AGENCY NAME] · [OFFICE PHONE]

Worker Name	Orientation Date
Presented By	Total Hours

Topic	Covered (✓)	Worker Initials
Agency mission, services and organization		
Job description and expectations		
Client rights and responsibilities		
Confidentiality and HIPAA		
Abuse, neglect and exploitation reporting		
Infection control and hand hygiene		
Bloodborne pathogens and PPE		
Safe lifting and fall prevention		
Emergency procedures and calling 911		
Emergency preparedness plan		
EVV, check-in / check-out and timesheets		
Visit documentation		
Professional boundaries, gifts and client property		
Dress code and ID badge		
Call-out and time-off rules		
Incident and injury reporting		
Complaint process		
Fraud, waste and abuse		
How to reach the office and on-call staff		

Worker Signature

Date

Presenter Signature

Date

Training Record

[AGENCY NAME] · [OFFICE PHONE]

Worker Name	Position	Hire Date	Annual Training Due

Date	Training Topic	Type (Initial / Annual / In-Service)	Hours	Method (Class / Online / Video)	Instructor	Score / Passed

Total Initial Hours	Total Annual Hours (this year)

Skills Competency Checklist

[AGENCY NAME] · [OFFICE PHONE]

Worker Name	Date
Evaluator	Evaluator Title

S = Satisfactory N = Needs More Training NA = Not Applicable

Skill	S	N	NA	Comments
Hand hygiene				
Putting on and removing gloves				
Bed bath / sponge bath				
Tub or shower assistance				
Oral care / denture care				
Hair care and shaving				
Dressing and undressing				
Toileting and incontinence care				
Transfer: bed to chair				
Using a gait belt				
Helping with walking / walker / cane				
Positioning in bed				
Feeding assistance				
Meal preparation and food safety				
Medication reminders (no administering)				
Recognizing and reporting changes				
Fall response				
Documentation and EVV				

Worker Signature Date

Evaluator Signature Date

Supervisory Visit Form

[AGENCY NAME] · [OFFICE PHONE]

Client Name	**Visit Date**
Caregiver Name	**Supervisor**
Caregiver Present? ☐ Yes ☐ No	**Visit Type** ☐ Routine ☐ Follow-up

Item	Yes	No	Notes / Action Needed
Plan of care is current and in the home	☐	☐	
Tasks are being done as planned	☐	☐	
Caregiver arrives on time and stays the scheduled hours	☐	☐	
Caregiver is professional and respectful	☐	☐	
Caregiver follows infection control	☐	☐	
EVV / time records are accurate	☐	☐	
Client is satisfied with services	☐	☐	
Client's needs have changed	☐	☐	
Any new safety concerns in the home	☐	☐	

COMMENTS, CLIENT FEEDBACK AND FOLLOW-UP NEEDED

Supervisor Signature

Date

Client or Representative Signature

Date

Incident Report

[AGENCY NAME] · [OFFICE PHONE]

Date of Incident	Time
Client Name	Location
Reported By	Date Reported to Office

TYPE OF INCIDENT

- ☐ Client fall
- ☐ Client injury
- ☐ Worker injury
- ☐ Medical emergency
- ☐ Suspected abuse / neglect
- ☐ Missing property / theft
- ☐ Medication concern
- ☐ Property damage
- ☐ Other:

WHAT HAPPENED (FACTS ONLY: WHO, WHAT, WHEN, WHERE)

ACTION TAKEN

- ☐ 911 called
- ☐ First aid given
- ☐ Family notified
- ☐ Physician notified
- ☐ Abuse hotline called
- ☐ Supervisor notified

OFFICE USE: REVIEW AND FOLLOW-UP

Reviewed By	Date Reviewed
Reported to Outside Agency?	Corrective Action

Person Reporting Signature

Date

Administrator Signature

Date

Incident Log

[AGENCY NAME] · [OFFICE PHONE]

Date	Client / Worker	Type	Brief Description	Reported Outside? (to whom)	Action / Closed Date

Complaint Form

[AGENCY NAME] · [OFFICE PHONE]

Date Received	Received By
Name of Person Complaining	Relationship to Client
Phone	Client Name

☐ Phone ☐ In person ☐ Written ☐ Email

DESCRIPTION OF COMPLAINT

INVESTIGATION AND FINDINGS

RESOLUTION

Acknowledged On (within 2 business days)	Resolved / Responded On
Person Satisfied? ☐ Yes ☐ No	Abuse/Neglect Involved? ☐ Yes ☐ No

Administrator Signature

Date

Complaint Log

[AGENCY NAME] · [OFFICE PHONE]

Date	Complainant	Client	Summary	Acknowledged	Resolved	Outcome

Client Emergency Information Sheet

[AGENCY NAME] · [OFFICE PHONE]

Keep a copy in the client's home (for example, on the refrigerator) and in the office.

Client Name	**Date of Birth**
Address	**Phone**
Emergency Contact 1 & Phone	**Emergency Contact 2 & Phone**
Physician & Phone	**Preferred Hospital**
Allergies	**Medical Conditions (as reported)**
Equipment (oxygen, wheelchair, etc.)	**Advance Directive / DNR on file?**

EMERGENCY PLAN

Priority Level (1, 2 or 3)	**Evacuation Destination**
Transportation in an Evacuation	**Pets / Special Needs**

Agency Office Phone: [OFFICE PHONE]	**After-Hours / On-Call: [ON-CALL PHONE]**

Client Priority List

[AGENCY NAME] · [OFFICE PHONE]

Level 1 = lives alone and cannot manage without help (contact first). Level 2 = some help but at risk without services. Level 3 = reliable family or other support. Update monthly.

Level	Client Name	Address	Phone	Emergency Contact & Phone	Special Needs (oxygen, etc.)	Status Checked

Staff Communication Tree

[AGENCY NAME] · [OFFICE PHONE]

In an emergency, the Administrator starts the calls. Each person calls the people listed under them and reports back.

Administrator: [ADMINISTRATOR NAME]	**Phone**
Alternate	**Phone**

Caller	Phone	Calls These Staff (name & phone)

Last Updated	**Updated By**

Client Satisfaction Survey

[AGENCY NAME] · [OFFICE PHONE]

Thank you for choosing [AGENCY NAME]. Please tell us how we are doing. Your answers help us improve.

Question	Excellent	Good	Fair	Poor
Caregivers arrive on time				
Caregivers are respectful and kind				
Caregivers do the tasks you need				
Office staff are helpful and easy to reach				
You are told about schedule changes				
Problems are handled quickly				
You feel safe with your caregivers				
Overall satisfaction				

☐ I would recommend this agency: Yes ☐ I would recommend this agency: No

WHAT COULD WE DO BETTER?

Name (optional)	Date

Job Descriptions

[AGENCY NAME] · [OFFICE PHONE]

Caregiver / Personal Care Aide

Reports to: [SUPERVISOR TITLE]

SUMMARY

Provides non-medical personal care, companionship and homemaking services to clients in their homes according to each client's plan of care.

DUTIES

- Help clients with bathing, dressing, grooming, toileting, transfers and walking as listed in the plan of care.
- Prepare meals and help with eating; follow special diets.
- Do light housekeeping, laundry and errands.
- Give medication reminders (does not administer medications).
- Provide companionship and encourage independence.
- Check in and out of every visit using the required EVV method; record tasks completed.
- Watch for and report changes in the client's condition, safety concerns and incidents the same day.
- Follow infection control, safety and confidentiality policies.
- Complete orientation, required training and annual training on time.

QUALIFICATIONS

- At least [MINIMUM AGE] years old.
- Passes required background and registry checks.
- Completes state-required training ([REQUIRED TRAINING HOURS]) and any required certification.
- Able to read, write and follow written instructions.
- Reliable transportation, valid driver license and auto insurance if driving is required.
- Able to lift up to [LIFTING REQUIREMENT] pounds and stand, bend and walk for long periods.

I have read this job description and can perform these duties with or without reasonable accommodation.

Worker Signature

Date

Scheduler / Office Coordinator

Reports to: [ADMINISTRATOR TITLE]

SUMMARY

Manages caregiver schedules, answers calls and keeps client and worker records organized.

DUTIES

- Schedule caregivers based on skills, availability, location and client preferences.
- Cover call-outs and missed visits; notify clients of changes.
- Answer phones and route calls and messages.
- Monitor EVV check-ins and correct exceptions with documentation.
- Maintain client and personnel files.
- Track authorizations, expiring certifications and training due dates.
- Assist with intake, payroll and billing preparation.

QUALIFICATIONS

- High school diploma or equivalent.
- Experience with scheduling or customer service preferred.
- Comfortable with computers, phones and scheduling software.
- Organized, calm under pressure and able to keep information confidential.
- Passes required background checks.

I have read this job description and can perform these duties with or without reasonable accommodation.

Worker Signature

Date

Client Care Supervisor

Reports to: [ADMINISTRATOR TITLE]

SUMMARY

Oversees client care quality and supervises caregivers in the field.

DUTIES

- Complete initial client assessments and home safety checks.
- Write and update plans of care.
- Complete supervisory visits [SUPERVISION FREQUENCY].
- Complete caregiver skills competency checks.
- Provide or arrange caregiver orientation, training and in-services.
- Respond to client concerns, incidents and complaints.
- Coach caregivers and recommend discipline when needed.

QUALIFICATIONS

- Meets [STATE] requirements for this role (for example, a nursing license if required).
- At least [SUPERVISOR EXPERIENCE] of home care or health care experience.
- Strong communication and teaching skills.
- Valid driver license and reliable transportation.
- Passes required background checks.

I have read this job description and can perform these duties with or without reasonable accommodation.

Worker Signature

Date

Administrator

Reports to: Owner / Governing Body

SUMMARY

Responsible for the daily operation of the agency and its compliance with state and federal rules.

DUTIES

- Manage daily operations, staff and budgets.
- Make sure the agency follows its license, this manual and all laws.
- Hire, train and supervise office and supervisory staff.
- Review incidents, complaints and quality results each quarter.
- Oversee billing, payroll and payer relationships.
- Lead the annual policy review and emergency plan review.
- Serve as the main contact with [STATE LICENSING AGENCY] and payers.

QUALIFICATIONS

- Meets [STATE] administrator qualifications.
- Experience managing a health care or home care business.
- Knowledge of state licensing rules, HIPAA and payer requirements.
- Strong leadership, organization and communication skills.
- Passes required background checks.

I have read this job description and can perform these duties with or without reasonable accommodation.

Worker Signature

Date