Client Information Form

Please fill out information as complete and to the best of your knowledge.

Please call us at (307) 460-1857 for assistance.

Instructions for submitting your information to us can be found on the last page of this form.

Name: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ Alternate Phone / Email: _____

Best Method to Contact:

- ☐ Postal Mail
- ☐ Phone
- ☐ Email

Best Time to Contact:

- ☐ Morning (8a - 12p)
- ☐ Afternoon (12p - 6p)
- ☐ Evening (6p - 8p)

For whom are you interested in getting information regarding Quality Living Solutions' services?

- ☐ Self
- ☐ Sibling
- ☐ Friend
- ☐ Spouse
- ☐ Grandparent
- ☐ Parent / In-Law

Name of person (other than self) whom services are being sought (care recipient): _____

PLEASE FILL OUT REMAINING INFORMATION FOR THE PERSON WHOM SERVICES ARE BEING SOUGHT (CARE RECIPIENT)

Gender: ☐ Male ☐ Female Age: ____ Birthdate: _____

When do you anticipate services/products will need to begin?

- ☐ Immediately
- ☐ Within 2 weeks
- ☐ Within 4 weeks
- ☐ Within 6 weeks
- ☐ 3 - 6 months
- ☐ 6 months - 1 year

Indicate the number of hours of support services the care recipient requires per week:

- ☐ 100 + hours
- ☐ 40 - 100 hours
- ☐ 20 - 40 hours
- ☐ 10 - 20 hours
- ☐ 0 - 10 hours

What, if any, existing medical conditions does the care recipient currently have? (select all that apply)

- ☐ ALS
- ☐ Alzheimer's / Dementia
- ☐ Ambulatory Problems
- ☐ Arthritis
- ☐ Cancer
- ☐ Colostomy
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Hearing Impaired
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension / High Blood Pressure
- ☐ Incontinence
- ☐ Joint Replacement
- ☐ Macular Degeneration
- ☐ Other Eye Disorder
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Respiratory Disease
- ☐ Stroke
- ☐ Surgical Recovery
- ☐ None / Unsure

Other: (please describe)

What type of medical/care assistance is the care recipient currently utilizing? (select all that apply)

- ☐ At home and living independently
- ☐ Assisted living facility / Retirement Community
- ☐ Hospital / Rehabilitation
- ☐ At home with some services in place
- ☐ At home with complete care
- ☐ Skilled nursing facility / Nursing home

From the list, which best describes the care recipient's primary need?

- ☐ In-Home Services / Products (that will allow the care recipient to continue to live safely at home)
- ☐ Eldercare Residence (assisted living, nursing home, independent living or senior community)
- ☐ Both Eldercare Residence and In-Home Options (options for both senior housing and/or in-home services)
- ☐ Medical Equipment and/or Eldercare Products (e.g. home medical products, medical equipment, ambulatory aids, personal medical alarms, etc.)
- ☐ Advisory and/or Consultative Services (e.g. legal advice, financial advice, estate planning, long term care planning, geriatric care management, family counseling, placement support, etc.)

Other - Explain: _____

Is the care recipient currently working? ☐ Yes ☐ No

If yes, what is the work schedule (nearest hour to hour)?

Sunday: ____ to ____ Monday : ____ to ____ Tuesday: ____ to ____ Wednesday: ____ to ____

Thursday: ____ to ____ Friday: ____ to ____ Saturday: ____ to ____

How far from home? ☐ Less than 1 mile ☐ 1 - 5 miles ☐ 5 - 10 miles ☐ 10 + miles

Mode of transportation to/from work? _____

What nutritional / allergy issues should we know about the care recipient? (please describe)

Allergies: _____

Eating Habits: _____

Eating Disorders: _____

Daily Medications: _____

Other: _____

What types of activities, hobbies, interests does the care recipient enjoy? (please describe)

Are there any shopping excursions or outings that the care recipient particularly enjoys? (please describe)

What spiritual / religious needs of the care recipient need to be considered? (please describe)

Is the care recipient willing and/or able to relocate in order to receive services? ☐ Yes ☐ No

Please provide the desired location for the service(s) or products the care recipient is seeking: _____
City State

Please select the care recipients preference for where care is provided: (select one)

- ☐ In-Home
- ☐ Assisted Living Facility
- ☐ Adult Day Care Facility
- ☐ Continuing Care Facility
- ☐ Independent Living / Senior Community
- ☐ Skilled nursing facility / Nursing home
- ☐ Group Home / Residence

Please select any services that the care recipient needs: (select all that apply)

- ☐ Adult Day Care / Respite Care
- ☐ Bill Paying
- ☐ Companion Services
- ☐ Financial Planning
- ☐ Geriatric Assessment / Evaluation
- ☐ Home / Safety Monitoring
- ☐ Home Healthcare (Medical)
- ☐ Home Renovation / Maintenance
- ☐ Homemaker / Household Services
- ☐ Hospice Services
- ☐ Insurance Services
- ☐ Live In Caregiver
- ☐ Meal Preparation
- ☐ Non-Medical Homecare
- ☐ Personal Care (e.g. bathing, grooming or toileting)
- ☐ Rehabilitation Services / Physical Therapy
- ☐ Transition Services (e.g. home sale, relocation, downsizing or asset liquidation)
- ☐ Transportation Non-Medical (e.g. grocery shopping, errands, etc.)
- ☐ Transportation Medical (Non-emergency)
- ☐ Visiting / Private Duty Nursing
- ☐ Visiting Physician / House Calls

Other (describe): _____

Please explain any additional or specific services that are required/needed for the care recipient:

Does care recipient have a vehicle or access to a vehicle for transportation? ☐ YES ☐ NO

Is care recipient a veteran of a branch of the armed services? ☐ YES ☐ NO If "yes" what branch? _____

How does the care recipient feel about receiving information from Quality Living Solutions, LLC and/or our affiliates?

☐ Very Receptive ☐ Somewhat Receptive ☐ Resistant to help ☐ Unaware

How will the services and/or products be paid for, what is the primary funding source for the care recipient?

- ☐ Private Pay
- ☐ Medicare
- ☐ Combination (Private Pay and Medicare)
- ☐ Medicaid / Public Assistance
- ☐ Long Term Care Insurance

Does the care recipient have a budget for "out-of-pocket" expenses? ☐ Yes ☐ No

If yes, approximately how much? $ _____ ☐ Weekly ☐ Monthly ☐ Annually

Please explain any additional information about the care recipient that would better help us serve them:

Thank you for taking the time to fill out our client data form. Your responses will be used by Quality Living Solutions, LLC to provide you with the best possible services. ALL INQUIRIES ARE COMPLETELY CONFIDENTIAL. Please visit http://quality-living-solutions.com to download a copy of our Privacy Policy.

Submission Instructions:

Be sure to save this form so that you have a copy for your files and future access to it.

There are 4 ways to submit your information to Quality Living Solutions, LLC:

1. Electronically: attach this form to an email addressed to office@quality-living-solutions.com

2. Regular Mail: Print this form and mail to: Quality Living Solutions
PO Box 1130
Laramie, WY 82073

3. Fax: Print this form and fax to: (307) 742-4475

4. Online: www.quality-living-solutions.com, left-side menu choose "Client Information Form", complete and submit.

Please call us at (307) 460-1857 with any questions or concerns and we'll be happy to assist you!

Print Form