CLIENT CARE APPLICATION

TRUSTED ROOTS CAREGIVING LLC

Phone: 575-268-3571
trustedrootscaregiving@gmail.com

Client and Applicant Information

Please complete this application as accurately as possible. Completion does not guarantee acceptance or immediate service.
A consultation and service assessment may be required before care begins.

PERSON COMPLETING THIS APPLICATION

Applicant / person completing form

Relationship to client

Phone number

Email address

Preferred contact
○ Phone ○ Email

CLIENT INFORMATION

Client legal name

Preferred name

Date of birth

Age

Gender / pronouns (optional)

Primary language

Home address

City

State

ZIP

County

Client phone

Client email (optional)

LIVING ARRANGEMENT

☐ Lives alone ☐ Lives with spouse/partner ☐ Lives with family ☐ Facility / group setting

Names of people living in the home

☐ Home has pets ☐ Smoking occurs in home ☐ Weapons are present in home

Please describe pets, smoking, weapons, or other home considerations

Emergency Contacts and Decision-Makers

PRIMARY EMERGENCY CONTACT

Full name

Relationship

Primary phone

Alternate phone

Email

SECONDARY EMERGENCY CONTACT

Full name

Relationship

Primary phone

Alternate phone

Email

LEGAL REPRESENTATIVE / AUTHORIZED DECISION-MAKER

☐ No legal representative ☐ Power of attorney ☐ Guardian ☐ Other

Name

Relationship / authority

Phone

Email

HEALTHCARE AND COMMUNITY CONTACTS (OPTIONAL)

Primary care provider

Provider phone

Pharmacy

Pharmacy phone

Case manager / social worker

Agency / phone

COMMUNICATION PREFERENCES

☐ Client may receive calls ☐ Client may receive text messages ☐ Client may receive email

☐ Representative may receive updates ☐ Emergency contact may receive urgent updates

Best days/times to contact

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Requested Services and Schedule

SERVICES REQUESTED

- ☐ Companionship
- ☐ Bathing assistance
- ☐ Dressing / grooming
- ☐ Toileting assistance
- ☐ Mobility / transfer assistance
- ☐ Meal preparation
- ☐ Medication reminders
- ☐ Light housekeeping
- ☐ Laundry / linens
- ☐ Shopping / errands
- ☐ Transportation / appointments
- ☐ Respite care
- ☐ Safety supervision
- ☐ Exercise / walking support
- ☐ Other

Other requested service or details

REQUESTED SCHEDULE

- ☐ One-time / short-term
- ☐ Ongoing weekly care
- ☐ Respite / as needed

Desired start date

Estimated hours per week

Preferred shift length

Day	Morning	Afternoon	Evening	Overnight
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Specific days, times, or scheduling notes

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Care Goals and Health Conditions

CARE GOALS

- ☐ Remain safely at home
- ☐ Reduce family caregiver stress
- ☐ Increase socialization
- ☐ Maintain personal hygiene
- ☐ Improve meal routine
- ☐ Attend appointments

Describe the client's most important goals

Trusted Roots Caregiving LLC provides non-medical services. This information helps us plan safe assistance and determine whether requested tasks are within our scope.

HEALTH CONDITIONS AND SUPPORT NEEDS

- ☐ Dementia / memory loss
- ☐ Diabetes
- ☐ Heart condition
- ☐ Stroke history
- ☐ Parkinson's disease
- ☐ Seizure disorder
- ☐ COPD / breathing condition
- ☐ Arthritis / chronic pain
- ☐ Vision impairment
- ☐ Hearing impairment
- ☐ Depression / anxiety
- ☐ Other

Diagnoses, recent hospitalizations, or important health details

ADDITIONAL HEALTH NOTES

Pain concerns, recent changes, or other information staff should know

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Mobility, Personal Care, and Nutrition

MOBILITY AND TRANSFERS

- ☐ Walks independently
- ☐ Uses cane
- ☐ Uses walker
- ☐ Uses wheelchair
- ☐ Needs standby assistance
- ☐ Needs hands-on assistance
- ☐ Unable to bear weight
- ☐ Recent falls
- ☐ High fall risk
- ☐ Uses hospital bed
- ☐ Uses lift device

Transfer instructions, equipment, or fall history

PERSONAL CARE AND CONTINENCE

- ☐ Independent with toileting
- ☐ Needs toileting reminders
- ☐ Needs toileting assistance
- ☐ Continent
- ☐ Occasional incontinence
- ☐ Uses briefs/pads

Personal care preferences, routines, or privacy considerations

ALLERGIES AND DIETARY NEEDS

Allergies (food, medication, environmental)

- ☐ No special diet
- ☐ Low sodium
- ☐ Diabetic
- ☐ Soft / pureed
- ☐ Other

Dietary restrictions, swallowing concerns, or meal preferences

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Medication, Behavior, and Home Safety

MEDICATION SUPPORT

- [ ] No medication reminders requested
- [ ] Verbal reminders only
- [ ] Observe self-administration

Medication schedule / reminder instructions

Important: Caregivers do not prescribe, prepare, alter, or administer medication unless expressly permitted by law, agency policy, and the service plan.

MEMORY, MOOD, AND BEHAVIOR

- [ ] Memory loss / confusion
- [ ] Wandering risk
- [ ] Sleep disturbance
- [ ] Anxiety / agitation
- [ ] Verbal aggression
- [ ] Physical aggression
- [ ] Self-neglect concerns
- [ ] Substance use concerns
- [ ] None known

Triggers, calming strategies, routines, or safety concerns

HOME SAFETY

- [ ] Stairs in home
- [ ] Loose rugs / clutter
- [ ] Oxygen in use
- [ ] Medical alert system
- [ ] Working smoke detectors
- [ ] Fire extinguisher
- [ ] Emergency exit plan

Known hazards or safety instructions

Preferences, Compatibility, and Payment

PREFERENCES AND COMPATIBILITY

Preferred caregiver qualities, language, cultural considerations, or gender preference

Activities, hobbies, interests, and conversation preferences

Tasks the client does not want assistance with

ANTICIPATED PAYMENT SOURCE

☐ Private pay ☐ Medicaid ☐ VA benefit / authorization ☐ Long-term care insurance

☐ Other

Other payment source

Member / policy / authorization number (optional)

Payer / plan name

Responsible party for payment

Billing phone / email

BILLING NOTES

Authorization status, billing contact instructions, or insurance notes

Authorizations and Signatures

ACKNOWLEDGMENTS AND AUTHORIZATIONS

- [ ] I understand this application is for non-medical caregiving services and is not a substitute for medical evaluation, nursing care, or emergency services.
- [ ] I certify that the information provided is accurate to the best of my knowledge and agree to notify Trusted Roots Caregiving LLC of important changes.
- [ ] I authorize Trusted Roots Caregiving LLC to contact the individuals and organizations listed in this application as reasonably necessary to coordinate requested services.
- [ ] I understand that services, rates, schedules, responsibilities, and cancellation terms will be described in a separate service agreement before care begins.
- [ ] I understand that in an emergency, caregivers may call 911 and notify the emergency contact according to agency policy and the client service plan.

AUTHORIZATION TO SHARE INFORMATION (OPTIONAL)

- [ ] I authorize information sharing for care coordination
- [ ] I do not authorize

People or agencies authorized to receive relevant care coordination information

Restrictions on information sharing

SIGNATURES

Client / authorized representative signature

Date

Printed name

Relationship to client

Trusted Roots representative

Date received

Office Use Only

Consultation date:

Assessment required: ☐ Yes ☐ No

Status: