COMMUNITY SERVICES
Senior Services

Print Form

SPECIAL NEEDS PROGRAM REQUEST FOR SERVICES

DATE OF REFERRAL	CARE MANAGER REQUESTING SERVICE	CARE MANAGER'S PHONE

CLIENT INFORMATION

CLIENT NAME			DATE OF BIRTH	GENDER
				☐ FEMALE ☐ MALE
ADDRESS	**CROSS STREETS**		**MARITAL STATUS**	
			☐ SINGLE ☐ DIVORCED	☐ MARRIED ☐ WIDOW
CITY	**STATE**	**ZIP**	**PHONE**	
EMERGENCY CONTACT			**HOME PHONE**	
RELATIONSHIP			**WORK PHONE**	

SERVICES REQUESTED

TYPE OF SERVICE REQUIRED (Personal, Chore, Homemaker, ERS)	PREFERED CAREGIVER	FREQUENCY (Monthly, Weekly)
	☐ FEMALE ☐ MALE	
MAKE ARRANGEMENTS WITH		**PHONE**

NEEDS / LIMITATIONS

ADLS

☐ HOUSEKEEPING	☐ MEDICATION REMINDER	☐ BATHING	☐ DRESSING
☐ TOILETING	☐ FEEDING	☐ LAUNDRY	☐ MEAL PREPARTION
☐ TRANSFERRING	☐ INCONTINENCE	☐ BLADDER	☐ BOWEL

REQUEST FOR SPECIAL NEEDS SERVICES

PHYSICAL LIMITATIONS

- ☐ VISION
- ☐ HEARING
- ☐ WHEELCHAIR
- ☐ WALKER
- ☐ FALLS
- ☐ SPEECH
- ☐ BREATHING
- ☐ QUAD CANE
- ☐ TRANSFERS
- ☐ BEDBOUND
- ☐ SMOKES

COGNITIVE STATUS: MEMORY LOSS

- ☐ MILD
- ☐ MODERATE
- ☐ SEVERE

LANGUAGE SPOKEN

PETS

☐ NO ☐ YES If YES, please describe: _____

TEMPERAMENT

- ☐ RESERVED
- ☐ OUTGOING
- ☐ RESISTANT
- ☐ AGGRESSIVE
- ☐ REPETITIVE
- ☐ WANDERER; Safe to return? ☐ NO ☐ YES

OTHER COMMENTS / SPECIAL INSTRUCTIONS

AGENCY CONTACT	DATE CONTACTED	PHONE

APPROVED BY _____ DATE _____

SOCIAL SERVICE SUPERVISOR