



IN-HOME CARE REQUEST

& INTAKE FORM

Dallas | Houston | Donna

Please complete this form as fully as possible. This is an initial request for in-home care; it is not an employment application, service agreement, or guarantee of service. Do not include Social Security numbers, bank or credit-card numbers, passwords, or other unnecessary financial information. For an immediate medical emergency or danger, call 911.

1. PERSON REQUESTING CARE

Full Legal Name

Preferred Name

Date of Birth (MM/DD/YYYY) Primary Phone

Alternate Phone

Email

Preferred Language

Service Address

City

State

ZIP Code

This request is being completed by:

☐ Person requesting care

☐ Family member / representative

☐ Other

If Other Than Client: Name

Relationship

Phone

2. EMERGENCY / CARE COORDINATION CONTACTS

Emergency Contact Name

Relationship

Phone

Primary Physician / Clinic (Optional)

Phone (Optional)

Preferred Hospital (Optional)

Currently Receiving Home Health or Hospice?

☐ Yes

☐ No

☐ Unsure

If Yes, Provider / Agency Name (Optional)

CARE NEEDS AND SUPPORT REQUESTED

Check all areas in which assistance may be needed. These questions help 1st Choice understand the request and determine whether the requested services are within agency scope. Additional assessment or documentation may be requested before services begin.

3. ACTIVITIES AND SERVICES

- | | |
|--|--|
| ☐ Bathing / showering | ☐ Grocery / personal shopping |
| ☐ Dressing | ☐ Light housekeeping |
| ☐ Grooming / personal hygiene | ☐ Laundry / linens |
| ☐ Toileting / incontinence support | ☐ Companionship / supervision |
| ☐ Mobility / walking | ☐ Errands |
| ☐ Transfers: bed / chair / wheelchair | ☐ Escort to appointments / places |
| ☐ Exercise / ambulation support | ☐ Medication reminders / permitted assistance |
| ☐ Meal planning, preparation, serving | ☐ Other support requested |

Describe Other Support or Special Priorities

Typical Level of Assistance Needed:

- | | | | |
|---|--|--|--|
| ☐ Reminders / cueing | ☐ Standby / supervision | ☐ Hands-on assistance | ☐ Full assistance |
|---|--|--|--|

4. HEALTH AND SAFETY CONSIDERATIONS

- | | |
|---|---|
| ☐ Fall risk / history of falls | ☐ Uses oxygen |
| ☐ Uses cane / walker | ☐ Recent hospitalization / surgery |
| ☐ Uses wheelchair | ☐ Skin / wound concerns |
| ☐ Memory loss / confusion | ☐ Swallowing or diet restrictions |

Relevant Health Conditions, Allergies, Safety Concerns, or Recent Changes (Optional at Initial Request)

Equipment Used at Home (for example: walker, wheelchair, hospital bed, lift, oxygen)

SCHEDULE, HOME SETTING, AND CARE PREFERENCES

5. REQUESTED SCHEDULE

Desired Start Date

Length of Care:

☐ Short-term

☐ Ongoing

☐ Unsure

Days Needed:

☐ Mon

☐ Tue

☐ Wed

☐ Thu

☐ Fri

☐ Sat

☐ Sun

Preferred Time(s):

☐ Morning

☐ Afternoon

☐ Evening

☐ Overnight

☐ Flexible

Approx. Hours Per Visit

Other Schedule Details

6. HOME SETTING

Residence:

☐ House

☐ Apartment

☐ Senior / assisted setting

☐ Other

Client Lives:

☐ Alone

☐ With spouse / partner

☐ With family / others

Home Considerations:

☐ Pets

☐ Smoking / vaping

☐ Stairs

☐ Limited accessibility

☐ None

Describe Pets, Stairs, Access, or Other Home-Safety Information

7. CARE PREFERENCES

Caregiver Preferences (language, communication, or personal-care comfort considerations)

Preferences will be considered when lawful, appropriate, feasible, and subject to caregiver availability.

What Would Make In-Home Care Successful? Anything We Should Know Before an Initial Call or Visit?

PAYMENT, CONTACT PREFERENCES, AND ACKNOWLEDGEMENTS

8. EXPECTED PAYMENT / PROGRAM SOURCE

- ☐ Private pay ☐ Medicaid / managed care ☐ Long-term care insurance ☐ Other
- ☐ Unsure / need guidance **Program / Plan Name (Do Not Include Member ID)** _____

9. PREFERRED OFFICE AND CONTACT METHOD

Nearest / Preferred Service Area:

- ☐ Dallas ☐ Houston ☐ Donna / RGV ☐ Not sure

Preferred Contact Method:

- ☐ Phone ☐ Email ☐ Text ☐ Any

Best Time _____

10. ACKNOWLEDGEMENTS

- ☐ 1. This is an initial request for information and care coordination. It does not guarantee service availability or acceptance.
- ☐ 2. An assessment, service plan, authorization, eligibility verification, rate agreement, or other documents may be required before services begin.
- ☐ 3. If requested needs are outside the agency's service scope, 1st Choice may recommend another provider or resource. Emergencies should be directed to 911.
- ☐ 4. I authorize 1st Choice In-Home Care Texas to contact me for intake, scheduling, and care coordination, and I confirm that the information I provided is accurate to the best of my knowledge.

Printed Name _____**Date** _____**Signature** _____**Relationship to Client (if applicable)** _____

RETURN INSTRUCTIONS: Return the completed form to the 1st Choice In-Home Care Texas office nearest you, or use another return method specifically provided by 1st Choice staff. Because this form may contain private care information, avoid sending it through unsecured email unless the office specifically instructs you to do so. Questions before completing the form? Call (956) 464-2937.

FOR OFFICE USE ONLY

Date Received _____**Office / Service Area** _____**Intake Coordinator** _____**Follow-Up Date** _____**Status** _____**Assessment Date** _____