VivaPath
HOME CARE
LIFE. CARE. COMPASSION. EVERY STEP OF THE WAY.

New Client Intake Form

Homemaker & Companion Services — Non-Medical Care

Please complete all sections as thoroughly as possible. All information is kept strictly confidential.

Purpose:
This form collects the information VivaPath needs to safely and effectively provide non-medical homemaker and companion services. It supports care planning, caregiver matching, scheduling, billing, and licensing compliance. It is not a medical record.

1. Client Information

Full Legal Name	Date of Birth	Age

Preferred Name / Nickname	Gender	Primary Language

Home Address	City	ZIP Code

Primary Phone	Alternate Phone	Email Address

Living Situation (alone, with family, facility, etc.)	Marital Status

Religion / Faith (Optional)	How Did You Hear About VivaPath?

2. Emergency & Authorized Contacts

Primary Emergency Contact

Full Name	Relationship to Client	Phone

Email Address

Authorized to Make Care Decisions?
☐ Yes ☐ No

Secondary / Authorized Contact

Full Name	Relationship to Client	Phone

Email Address

Authorized to Make Care Decisions?
☐ Yes ☐ No

Legal Decision-Maker / Authorized Representative (if applicable)

Full Name	Relationship	Phone

Authority Type:
☐ Medical Decisions ☐ Non-Medical / Care Decisions ☐ Financial / Payment Decisions

Legal Document on File:
☐ Power of Attorney (POA) ☐ Health Care Surrogate ☐ Legal Guardian ☐ Other / Pending

If Other, please specify:

Copy of Documentation on File?
☐ Yes ☐ No ☐ Pending

3. Health & Safety Overview

VivaPath caregivers do not provide medical care. This section helps us match appropriate non-medical support and maintain a safe environment — it is not a medical record.

Primary Care Physician (Name & Practice)	Physician Phone

Pharmacy Name & Phone

Known Allergies (medications, food, environmental):

Mobility Status:
☐ Independent ☐ Uses Cane ☐ Uses Walker ☐ Uses Wheelchair

Fall Risk in Past 12 Months:
☐ Yes ☐ No ☐ Unknown

General Safety-Relevant Notes Caregivers Should Know (optional):

4. Medication Reminder Information

Caregivers provide verbal reminders only and do not administer, sort, pour, or handle medications.

Does the Client Need Medication Reminders?
☐ Yes ☐ No

Reminder Time(s) Requested

Medications to Remind (name only — dosing not required for reminders):

Medication Name	Reminder Time(s)

5. Memory & Safety Considerations

Memory Support Needs:
☐ No Concerns ☐ Occasional Forgetfulness
☐ Needs Reminders for Daily Routines ☐ Needs Supervision for Safety

Wandering Risk:
☐ Yes ☐ No ☐ Unknown

Safety-Relevant Behaviors (check all that apply):

☐ Agitation / Restlessness ☐ Anxiety

☐ Increased Confusion in Evenings ☐ Resistance to Daily Routines

☐ Withdrawal / Low Mood ☐ Sleep Disturbances

Additional Notes on Memory / Safety Considerations:

6. Dietary & Household Preferences

Dietary Restrictions or Special Diet (e.g., diabetic-friendly, low-sodium, vegetarian, religious/cultural diet):

Favorite Foods / Meals:

Foods to Avoid / Dislikes:

Preferred Grocery Store

Hobbies, Interests & Preferred Activities (for companion engagement):

Daily Routine Notes (wake time, meal times, nap time, bedtime, etc.):

Topics or Situations to Avoid (optional):

7. Care Needs & Requested Services

Select all services requested:

☐ Companion Care ☐ Homemaker / Light Housekeeping ☐ Meal Preparation

☐ Grocery Shopping / Errands ☐ Medication Reminders ☐ Transportation Assistance

☐ Respite Care ☐ Overnight Assistance ☐ Live-In Care

☐ Safety Monitoring / Companionship Supervision ☐ Laundry Assistance

Other (specify)

Additional Notes or Special Requests:

8. Schedule & Coverage Needs

Requested Start Date	Number of Hours Per Visit	Visits Per Week

Preferred Days:
☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday
☐ Friday ☐ Saturday ☐ Sunday

Preferred Shift Times:
☐ Morning (7am–12pm) ☐ Afternoon (12pm–5pm)
☐ Evening (5pm–10pm) ☐ Overnight (10pm–7am)

Frequency:
☐ Daily ☐ Several Times Per Week ☐ Weekly
☐ Bi-Weekly ☐ As Needed

Overnight or Live-In Care Requested:
☐ Yes ☐ No

9. Caregiver Preferences

Gender Preference:
☐ Male ☐ Female ☐ No Preference

Language Preference (Optional)	Cultural / Ethnic Preferences (Optional)

10. Home Environment, Access & Safety

Pets in Home (type / breed)

Smoking in Home:
☐ Yes ☐ No

Accessibility Concerns (check all that apply):
☐ Stairs / Steps ☐ Narrow Doorways
☐ No Elevator ☐ Uneven Flooring
☐ Limited Lighting ☐ No Grab Bars / Rails
☐ Clutter / Hoarding ☐ Unsafe Neighborhood

Home Access Instructions (key location, lockbox / gate / alarm code, parking notes):

Additional Home Safety Notes:

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11. Funding & Referral Information

Veteran or Surviving Spouse of a Veteran? (may qualify for VA Aid & Attendance benefit)
☐ Yes ☐ No ☐ Unknown

Long-Term Care Insurance Policy?
☐ Yes ☐ No

Insurance Company (if applicable)	**Policy Number**

Referral Source (person, agency, or facility, if applicable)	**Referral Contact Phone / Email**

12. Payment & Billing Information

Responsible Party for Payment	**Relationship to Client**

Billing Address	**City / State / ZIP**

Billing Phone	**Billing Email**

Preferred Payment Method:
☐ Private Pay — Credit / Debit Card ☐ ACH / Bank Transfer
☐ Check ☐ Other

If Other, please specify:

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13. Consent & Acknowledgment

By signing below, I confirm that the information provided in this form is accurate and complete to the best of my knowledge. I understand that VivaPath Home Care provides non-medical Homemaker & Companion Services only and does not provide skilled nursing, medical treatment, or clinical care. I authorize VivaPath Home Care to use the information provided to develop a non-medical care plan and assign appropriate staff. I understand that services are provided on a private-pay basis and that rates are subject to change with advance written notice. I acknowledge receipt of the VivaPath Service Rate Sheet and agree to the terms outlined in the Service Agreement provided separately.

Client or Authorized Representative — Printed Name	**Signature**

Date	**Relationship to Client (if not client)**

VivaPath Representative — Printed Name	**Signature & Date**

INTERNAL USE ONLY — DO NOT RETURN TO CLIENT

Intake Completed By	Date Received	Client ID / File #

Assigned Caregiver(s)	Scheduled Start Date

Rate Confirmed?
☐ Yes ☐ No

Notes / Follow-Up Required: