Valley Area Agency On Aging
Answers, Action, & Advocacy for All Things Senior!

Service Request Form
(810) 239-7671 Fax: (810) 244-0980
http://www.valleyareaaging.org

**Date:atti

**Has client been informed of this referral? ☐Yes ☐No
**Is the client able to answer for themselves? ☐ Yes ☐ No

Client Information

Full Name: Enter text (*Last*) Enter text (*First*)

Address: Enter text (*Street Address*) Enter text (*Apartment/Unit #*)

Enter text (*City*) Enter text (*State*) Enter text (*Zip Code*)

Phone #: Enter number **Race:** Enter text **Gender:** Enter text **Social Security #:** Enter text

Birth Date: Enter a date **Marital Status:** Enter text **Residence** (alone, spouse, child, etc)**:** Enter text

Gross Monthly Income: (estimated) **$** Enter amount

Assets: ☐ **Below $2000** ☐ **Above $2000**

Do you have: ☐ **Medicare** ☐ **Medicaid** ☐ **Both** ☐ **None**

Have you been hospitalized in the last 30 days: ☐ **Yes** ☐ **No** **If yes, where?** Enter text

Current Diagnosis: Enter text

Are you currently in the hospital? ☐ Yes ☐ No **Anticipated discharge date:** Enter text.

Requested Services: ☐ **Home Help** ☐ **Respite** ☐ **Transportation** ☐ **Personal Care** ☐ **Emergency Response System (PERS)** ☐ **Home Delivered Meals** ☐ **Resources** ☐ **Nursing Home Transition** ☐ **Adult Foster Care** ☐ **Adult Day Center**

Preliminary Information

Is there currently someone paid to provide assistance in the home?	☐ **Yes; If Yes, whom?:** Enter text ☐ **No**	Are you on oxygen 24/7?	☐ **Yes** ☐ **No**
Do you live alone?	☐ **Yes If No, with whom?** Enter text ☐ **No**	Do you have significant memory loss?	☐ **Yes** ☐ **No**
Are you able to get out of bed by yourself?	☐ **Yes** ☐ **No**	Are you able to prepare your own meals?	☐ **Yes** ☐ **No**
Do you currently receive Dialysis?	☐ **Yes** ☐ **No**	Are you able to complete personal care tasks independently? (bathing, grooming, dressing, toileting etc.)	☐ **Yes** ☐ **No**
Do you currently drive?	☐ **Yes** ☐ No	Do you currently use assistive devices? ☐ Yes ☐ No **If yes, which one?**	☐ **Wheelchair** ☐ **Cane** ☐ **Walker** ☐ **Other** Enter text
Do you have a history of mental illness?	☐ **Yes If yes, please explain:** ☐ **No** Enter text		

Contact/Referral Information

If client cannot answer for themselves, whom should we contact? ☐ Family/Friend ☐ Legal Guardian

Name: Enter text

Relationship: Enter text

Phone: Enter text

Email: Enter text

Other Comments: Click or tap here to enter text.

Referred by: (Please provide email address)
Would you like a follow up on referral? ☐ Yes ☐ No

****Name:** Enter text

**Email: Click or tap here to enter text.

Agency/Title: Enter text

Phone: Enter text