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

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

Date:

Client Information

Full Name: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

Phone #: **Race:** **Gender:**

Birth Date: **Marital Status:** **Residence** (alone, spouse, child, etc):

Gross Monthly Income: (estimated) $

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? _____

Current Diagnosis: _____

Are you currently in the hospital? ☐ Yes ☐ No **Anticipated discharge date:** _____

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 ☐ Millage

Preliminary Information

Is there currently someone paid to provide assistance in the home?	☐ Yes, If yes, whom: ☐ No	Are you on oxygen 24/7?	☑ Yes ☐ No
Do you live alone?	☐ Yes If No, with whom? ☐ 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	Do you currently use assistive devices? ☐ Yes ☐ No If yes, which one?	☐ Wheelchair ☐ Cane ☐ Walker ☐ Other
Do you have a history of mental illness?	☐ Yes If yes, please explain: ☐ No		

Contact/Referral Information

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

Name: _____

Relationship: _____

Phone: _____

Email: _____

Other Comments:

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

****Name:** _____

**Email: _____

Agency/Title: _____

Phone: _____