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DIRECT SERVICE PROVIDER

ADMISSION-INTRODUCTION FORM

CLIENT LAST NAME	CLIENT FIRST NAME	CLIENT MIDDLE INITIAL	DATE OF VISIT
CLIENT DATE OF BIRTH	SOCIAL SECURITY NUMBER		COUNTY

INTRODUCTIONS:

- ☐ Yes ☐ No Community Services: _____
- ☐ Yes ☐ No Program Purpose: _____
- ☐ Yes ☐ No Worker: _____
- ☐ Yes ☐ No Given Hours of Operation
- ☐ Yes ☐ No Given Business Cards with Office Number & Contracts
- ☐ Yes ☐ No Explain 60 Day Nursing/Supervisory Visit/Review

Paperwork Discussed:

- ☐ Yes ☐ No Advanced Directives
- ☐ Yes ☐ No Executed Living Will
- ☐ Yes ☐ No Executed Power of Attorney
- ☐ Yes ☐ No Notified of Right to Complaint/Grievance Policy
- ☐ Yes ☐ No Emergency Contact/Disaster Preparedness
- ☐ Yes ☐ No Reviewed Rights and Responsibilities

Approved Services:

_____ Homemaker
_____ Personal Care
_____ Unskilled Respite
_____ Skilled Respite
_____ Companion
_____ Nursing Services LPN/RN
_____ Personal Assistance
_____ Adult Day Health Care

Schedule of Services: _____
_____
_____
_____

Case Manager Present: _____

Services Begin: _____

General Findings: _____

Comments/Summary: _____
_____
_____
_____

_____ _____

Client/Caregiver/Responsible Person Signature Date Nurse/Supervisor Signature Date