

Arcadia Home Health/Home Care Services

APPLICATION

Application Date: \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Number/Street City State Zip

Billing Address \_\_\_\_\_  
(If different than mailing address)

Phone \_\_\_\_\_ Marital Status S M W D Ethnicity \_\_\_\_\_

Presently Lives With \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Religion \_\_\_\_\_ Former Occupation \_\_\_\_\_

<p><b>1<sup>st</sup> Contact person</b> _____</p> <p>Bus _____ Res _____ Cell _____ Fax _____</p> <p>Address _____ Number/Street City State Zip</p> <p><b>2<sup>nd</sup> Contact person</b> _____</p> <p>Bus _____ Res _____ Cell _____ Fax _____</p> <p>Address _____ Number/Street City State Zip</p>
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Durable Power of Attorney for Healthcare \_\_\_\_\_  
Name Phone

Durable Power of Attorney for Finances \_\_\_\_\_  
Name Phone

Referred by \_\_\_\_\_  
Individual / Agency

Types of Service Requested: Personal Care Limited Healthcare \_\_\_ Monitoring of Vital Signs \_\_\_ Exercise  
\_\_\_ Medication Supervision/Reminders Transport/Escort Homemaker Home Delivered Meals Home Spa

Days of Service Requested: \_\_\_ Sun \_\_\_ Mon \_\_\_ Tues \_\_\_ Wed \_\_\_ Thurs \_\_\_ Fri \_\_\_ Sat

Primary Physician \_\_\_\_\_  
Name Phone Fax

Responsible Person's Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Person's Printed Name \_\_\_\_\_