arrangeCARE *PC*
2900 W. Anderson Lane C-100 #155
Austin Texas 78757
512-814-3228
EIN 80-0320807
ramonab@arrangecare.com
inap@arrangecare.com
www.arrangecare.com

arrangeCARE
Elder Care & Special Needs
Case Management

INITIAL INFORMATION

Date _______________ **Referred by (Person/Company)** ___________________________________

Your Name _______________________________ **Landline** _____________________________

Address __________________________________ **Mobile Phone** _____________________________

__________________________________ **Primary Email** ____________________________

Client Name ______________________________ **Your Relationship to Client**__________________

HOW MAY WE HELP YOU?____

____

____

____

____

CLIENT INFORMATION

Name ____ **Phones** __________________________

Address ____ __________________________

____ **Email** __________________________

DOB	**Gender**	**Spouse/Partner**
Age Now	**Marital Status**	**Date of Change**
SSN	**Employment Status**	
Medicare #	**Veteran?**	**Service-connected disability?**
Medicaid #	**Religion**	
Ethnicity	**Living Environment**	
Language(s)	**Long Term Care Insurance**	
Medicare Coverage (e.g., A, B, D)	**Type of Medicare Plan**	
Medicare Supplemental Policy		
Monthly Income		
Public Benefits (e.g., Medicaid Waiver Programs; Medicare Special Help)		

Medication List (please include Over-the-Counter medications)

Medication	Prescribed By	Dosage	How Taken	When Started

FINANCIAL

Monthly Income_________________

Responsible Party ______________________ **Power of Attorney?** **Yes** ________ **No** _______

Address _______________________________ **Phones** ____

_______________________________ ____

_______________________________ ____

Email: ______________________________________

LEGAL

Guardian ____________________________ Type of Guardianship ______________________

Address ____________________________ Phones ______________________________________

____________________________ ______________________________________

____________________________ ______________________________________

Email: ______________________________________

Others Involved (Family, Friends…)

Name	Relationship	Phone/Email

Primary Medical Provider

Name	Phone/Email

Other Medical Providers (MDs, Dentists, Hospitals, Home Health Agencies, DME, etc.)

Name	Phone/Email

Durable Medical Equipment (DME) and/or Assistive Devices Used (e.g., eyeglasses, walkers, canes, wheelchairs, hearing aides, communication devices, prostheses)

Non-Medical Providers (e.g., Attorneys, Accountants, Trust Officers, Social Service Agencies)

Name	Contact Info

Private Insurance Detail (Long-term Care, Medicare Supplemental, etc.)

Carrier	Policy Type	Group & Policy Number	Phone Number

As applicable, please check off and provide copies of the patient's:

Do Not Resuscitate Order _______

Durable Power of Attorney for Health Care ________

Guardianship Orders _______

Other Probate Orders ______

Please return completed form and attachments to arrangeCARE PC