Treasure Coast Senior Care

Your Name:

Phone:

Is this a cell phone?

☐ Yes ☐ No

Email Address:

Your Contact Preference:

☐ Email ☐ Phone ☐ Text ☐ No Preference

Address:

City:

State:

ZIP Code:

or outside USA:

When would you like services to begin? (Please select one)

☐ Immediately ☐ Within 2 Weeks ☐ Within 4 Weeks ☐ Within 8 Weeks

Best to Contact During:

ZIP Code where care Is needed:

Do you have an Interest in receiving a Free In Home Care Consultation'?

☐ Yes ☐ No

☐ **Join the Tcseniorcare Community**

We'll send you periodic updates about resources designed to help your loved one live at home.

SERVICES

Please select any services that you believe are required for your loved one: (Please select all that apply)

- Homemaker/Household Services
- Medication Reminders
- Light Housekeeping Laundry
- Live in Homecare
- Companion Services
- Meal Preparation
- Hobbies, Shopping, Appointments, Reading
- Homecare for a Veteran or Surviving Spouse
- Assistance with Ambulation or Mobility
- Transportation Non-Medical (e.g. Errands, Shopping)
- Home/ Safety Monitoring
- Personal Care (e.g. Bathing, Dressing, Personal Hygiene)

Who is the loved one that you are interested in getting information regarding eldercare services?

- Self
- In-Law
- Spouse
- Sibling
- Parent
- Other Relative
- Child
- Friend
- Grandparent
- Employee

Please provide the following information about your loved one.

Gender

Age

What, if any, existing medical conditions does your loved one have?

- ALS
- Alzheimer's / Dementia
- Ambulatory Problems
- Arthritis
- Cancer
- Colostomy
- Depression
- Diabetes
- Hearing Impaired
- Heart Disease
- Incontinence
- Joint Replacement
- Other Eye Disorders & Diseases
- Osteoporosis
- Parkinson's
- Respiratory Disease
- Stroke
- Surgical Recovery
- Disease or Condition Not Listed
- Quadriplegic
- Macular Degeneration/Low Vision
- None / Unsure

Which of the following best describes your loved one's current living arrangement? (Please select one)

- At home and living independently
- Living with Family
- At home with some services in place
- Hospital or rehabilitation facility
- Assisted living facility
- Skilled Nursing Facility / Nursing Home

Do you need or want any of the following Consulting / Advisory Services? (Select all that apply)

- Geriatric Care Management
- Certified Senior Advisor
- Legal / ElderLaw Services
- Senior Financing Options (e.g., Reverse Mortgages, Life Settlements, etc.)

What funding source will you be using as the primary payer for the services? (Please select one)

- Private pay
- Veterans Benefits
- Long Term Care Insurance

How much have you budgeted for these "out-of-pocket" expenses? (Please select one)

- Less than $250 per week
- $1,001 to $1,500 per week
- $250 to $500 per week
- Over $1,500 per week
- $501 to $1,000 per week

Please indicate the number of hours of support services that you estimate your loved one will require. (Please select one)

- 4 hours/day a couple of times a week
- 4 hours/day daily
- Less than 4 hours/day
- More than 4 hours/day
- 24/7 services
- Just on the weekends
- Live in services

How would you describe your loved one's feelings about receiving assistance? (Please select one)

- Very Receptive
- Resistant to Help
- No Preference
- Somewhat Receptive
- We have not discussed it yet

Please include any additional information that you think may be helpful.