GENERAL INQUIRY FORM

Parker Legacy Care, LLC
Senior Placement & Home Care Consultant

CLIENT INFORMATION

Client Full Name: _____

Date of Birth: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Email Address: _____

Current Address: _____

Preferred Contact Method: _____

Marital Status: _____

Veteran Status: _____

PRIMARY CONTACT / RESPONSIBLE PARTY

Primary Contact Name: _____

Relationship to Client: _____

Phone Number: _____

Email Address: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

CURRENT CARE SITUATION

Current Living Arrangement: _____

Primary Diagnosis / Medical Concerns: _____

Current Providers or Services: _____

Recent Hospitalizations or Rehab Stays: _____

Mobility Assistance Needed: _____

Memory / Cognitive Concerns: _____

Medication Management Needs: _____

SERVICES OF INTEREST

☐ Assisted Living Placement

☐ Memory Care Placement

☐ Independent Living Guidance

☐ Skilled Nursing Referrals

☐ In-Home Care Guidance

☐ Respite Care Options

☐ Transition Support

☐ Family Care Planning

☐ Community Tour Coordination

☐ Other: _____

CARE PREFERENCES & GOALS

Please describe the client's current needs, concerns, goals, preferred location, budget considerations, or additional information relevant to placement or care coordination:

_____

_____

_____

_____

_____

_____

CONSENT TO COMMUNICATION

By signing below, I acknowledge that Parker Legacy Care, LLC may contact me regarding services, care coordination, placement assistance, follow-up communication, and related support services. I understand that information shared may include protected health information necessary for care coordination and referral assistance in accordance with HIPAA privacy standards and applicable AHCA guidelines.

HIPAA & PRIVACY ACKNOWLEDGMENT

Parker Legacy Care, LLC maintains the confidentiality and privacy of all client information in accordance with HIPAA privacy standards and applicable state regulations. Information collected through this inquiry form is used solely for evaluating care needs, coordinating services, placement guidance, and communication with authorized parties.

SIGNATURES

Client / Representative Signature: _____

Printed Name: _____

Date: _____