Consumer Home Care Questionnaire

Thank you for taking the time to complete the Consumer Home Care Questionnaire for Homemaker and Companion Services. This questionnaire will help us understand your needs and preferences so we can provide the best possible care for you in your local community or in the comfort of your own home!

Lead Information

Estimated Start Date:	
Point of Contact:	
Email:	
Phone Number:	
Care Needed For:	

Why Care is Needed:

Health Condition(s):	
Location where care is needed:	
Services needed:	Homemaker and Companion Services

This document serves as a Consumer Home Care Questionnaire Form

CLIENT BACKGROUND

1. Tell us a little about yourself and your daily routine:

2. What kind of health concerns or diagnoses are you currently managing?

3. Have you had in-home care services before? If so, what was your experience?

MEDICAL & PERSONAL CARE NEEDS

1. What types of medical assistance do you need at home? (e.g., medication management, wound care, mobility assistance)

2. Do you require help with daily living activities? (e.g., bathing, dressing, eating, toileting)

3. Are there specific times of day when care is most important?

4. Do you use any medical equipment (oxygen, walker, etc.)?

CARE PREFERENCES

1. Do you prefer a male or female caregiver?

☐ Male

☐ Female

2. Are there language or cultural preferences we should be aware of?

3. How involved would you or your family like to be in planning and monitoring your care?

4. What qualities are most important to you in a caregiver?

HOME ENVIRONMENT & SAFETY

1. Can you describe your home layout? Are there stairs or potential fall hazards?

2.Do you live alone or with others?

☐ Alone

☐ With Others

3. Are their pets in the home?

☐ Yes

☐ No

4. Is there someone available in case of an emergency?

☐ Yes

☐ No

If yes, who (First and Last Name)? _____

SCHEDULE & AVAILABILITY

1. Are you looking for temporary or ongoing care?

☐ Temporary

☐ Ongoing

2. Please specify your preferred days and times for care services, along with the anticipated number of hours required per day and per week:

➨ EXAMPLE:

WEEK	SU	✔
HOURS	SU	8
TIMES	SU	0900-1700

WEEK	SU		MO		TU		WE		TH		FR		SA	
HOURS	SU		MO		TU		WE		TH		FR		SA	
TIMES														

FAMILY & SUPPORT SYSTEM

1. Who is your primary contact or decision-maker?

First and Last Name: _____

Contact Phone No.: _____

2. Are family members involved in your care or nearby to assist?

☐ Yes

☐ No

If yes, please provide details:

3. Would you like us to keep any family members regularly updated?

☐ Yes

☐ No

If yes, who (First and Last Name)? _____

FINANCIAL & SERVICE EXPECTATIONS

1. Are you paying privately or through Insurance/Medicaid/~~Medicare~~?

☐ Private

☐ Insurance

☐ Medicaid

☐ ~~Medicare~~

2. What is your weekly budget for home care services? _____

WRAP-UP

1. Do you have any questions or concerns about receiving home care?

2. Is there anything else you would like us to know about your preferences or goals?

3. Would you like to meet the caregiver before services begin?

☐ Yes

☐ No

Consumer and/or Authorized Representative Signature(s)

Print Name of Consumer: _____

Consumer Signature: _____ Date: _____

Printed Name of Authorized Representative: _____

Authorized Rep. Signature: _____ Date: _____