



ALPHA ALLIANCE HOME CARE LLC

4700 Torreys Peak Court, Antioch, CA 94531 | (925) 550-1448 | alpha_alliancehomecare@yahoo.com
RN-Owned | Licensed Home Care Organization - CA Dept. of Social Services

INTAKE ASSESSMENT / PLAN OF CARE

DATE: _____

A. CLIENT INFORMATION

Client Name: _____	Care Coordinator: _____
Address: _____	Referred By: _____
City / State / ZIP: _____	Hospital / Facility: _____
Phone Number(s): _____	Room # / Phone: _____
Email: _____	Languages Spoken: _____
DOB: _____	Age: _____
Gender: _____	Marital Status: _____
Weight: _____	Height: _____
Past Profession: _____	Religion / Church: _____
DNR: ☐ Yes ☐ No	
Advance Directives: ☐ Yes ☐ No ☐ Refer to POLST	
Lives Alone: ☐ Yes ☐ No	
Anyone Smokes: ☐ Yes ☐ No	
Legal Status: ☐ Self ☐ Guardian ☐ Power of Attorney	
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	
Race: ☐ Asian ☐ White ☐ African-American ☐ Other	
Primary Contact: _____	Phone / Email: _____
Relationship: _____	Address: _____
Secondary Contact: _____	Phone / Email: _____
Relationship: _____	Address: _____

B. ASSESSMENT

Principal Diagnosis: _____

Care Goals: _____

Mental Status: ☐ Oriented ☐ Forgetful ☐ Memory Loss (ST/LT) ☐ Disoriented / Wanderer ☐ Agitated / Combative ☐ Lethargic
☐ Depressed / Mood Changes ☐ Communication Needs

Medication Reminders: ☐ AM ☐ Noon ☐ PM ☐ Bedtime

Who Manages Medications: _____ Drug Allergies: _____

Functional Limitations: ☐ Bed Rest ☐ Partial Weight Bearing ☐ Wheelchair ☐ Independent at Home ☐ Up as Tolerated ☐ Transfer Bed/Chair
☐ Crutches ☐ Cane ☐ Walker ☐ Exercises Prescribed ☐ No Restrictions

Other (specify): _____

Dementia / Alzheimer's: ☐ Forgetful ☐ Mild ☐ Moderate ☐ Severe

Symptoms: ☐ Confusion ☐ Hallucinations ☐ Speaking/Conversing ☐ Sundowner ☐ Verbal Cues ☐ Poor Eating ☐ Paranoia/Anxiety
☐ Withdrawn/Depression ☐ Poor Judgement

Triggers: _____



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INTAKE ASSESSMENT / PLAN OF CARE (CONTINUED)

DATE: _____

PHYSICAL & PERSONAL CARE NEEDS

Balance: _____

Mobility: ☐ Assist w/ Ambulation ☐ Assist w/ Transfers ☐ Bed / Chair Only

Equipment: ☐ Grab Bars ☐ Shower Chair ☐ Assistive Devices ☐ Other

Vision: ☐ R. Eye Loss ☐ L. Eye Loss ☐ Peripheral Only ☐ Wears Glasses

Hearing: ☐ Hard of Hearing ☐ Hearing Aids ☐ Deaf - Complete ☐ Deaf - Partial

Exercise: ☐ Encourage Exercise ☐ ROM Exercises ☐ PT Prescribed / Rehab Regimen

Bathing: ☐ Complete ☐ Partial ☐ Tub ☐ Shower ☐ Sponge Bath

Shower Schedule: _____

Skin Care: ☐ Dry / Flaky ☐ Frail / Fragile ☐ Moisturizer

Hair Care: ☐ Wash & Dry ☐ Wash & Set ☐ Comb & Brush Only

Oral Care: ☐ Brush & Floss ☐ Denture Care ☐ Mouth Rinse

Dressing: ☐ Self Dress ☐ Help Select Clothes ☐ Assist w/ Dressing ☐ Full Assist ☐ Assist When Asked

Toileting: ☐ Bathroom ☐ Bedpan ☐ Reminders ☐ Urinal ☐ Colostomy ☐ Commode ☐ Catheter

Incontinence: ☐ Urine ☐ Stool ☐ Depends ☐ Accident Protection ☐ Full Incontinence ☐ Weigh Client

MEALS, HOUSEHOLD & DAILY ROUTINE

Meal Assistance: ☐ Cooking ☐ Prep ☐ Feeding

Appetite: ☐ Good ☐ Poor ☐ Needs Improvement

Shopping Done By: _____ Breakfast / Lunch / Dinner Times: _____

Diet: ☐ Normal ☐ Liquid Only ☐ Feeding Assist ☐ Assist w/ Meals ☐ Low Sodium ☐ Diabetic

Food Allergies: _____ Other: Swallowing Issues / Encourage Liquids: _____

Light Housekeeping: ☐ Laundry ☐ Change Linens ☐ Clean Kitchen ☐ Clean Bathroom ☐ Make Beds ☐ Sweep ☐ Vacuum ☐ Mop / Dust ☐ Trash
☐ Water Plants

Pets: ☐ Cat ☐ Dog ☐ Clean Litter Box ☐ Feeding ☐ Walk Dog ☐ Vaccinated

Activities: ☐ Accompany to Appointments ☐ Outdoor Recreation ☐ Public Transportation

Driving: ☐ Client Drives ☐ Caregiver Drives - Client's Car ☐ Caregiver Drives - Aide's Car

Wake Up Time: _____ Bed Time: _____

Nap Time: _____ Caregiver Gender Preferred: _____

Sleep: ☐ Sleeps Through Night ☐ Frequently Wakes Up ☐ Needs Caregiver at Night ☐ Optional: CG Interview

Caregiver Qualities & Skill Requirements: _____

CARE LEVEL

Level 1: ☐ Cooking / Meal Prep ☐ Light Housekeeping ☐ Appts / Errands / Shopping ☐ Light Exercise ☐ Med Reminders

Level 2: ☐ Feeding Assist ☐ Bathing / Dressing Assist ☐ Ambulation ☐ Toileting ☐ Fall Risk / Gait

Level 3: ☐ Transfer Assist (H/M/L) ☐ Incontinence Care ☐ Bed Bound ☐ Hospice ☐ Dementia



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DATE: _____

C. STAFFING / BILLING

Start Date: _____

Deposit: \$ _____

Hourly Schedule: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Live-In Schedule: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Hourly Rate: \$ _____ / hour _____

Live-In Rate: \$ _____ / day _____

Payment Type: ☐ Private Pay ☐ Insurance ☐ Long-Term Care Policy

Insurance / LTC Company: _____

LTC Policy #: _____

LTC Contact Info: _____

Last 4 of SSN: _____

Mode of Payment: ☐ Cash ☐ Check ☐ Credit / Debit Card ☐ ACH ☐ Zelle

Send Bill To - Name: _____

Conservator / Trustee - Name: _____

Address: _____

Address: _____

Email: _____

Phone: _____

Notes / Home Environment Safety Concerns:

Client / Representative Signature: _____

Date: _____

Alpha Alliance Representative: _____

Date: _____

LEGEND: DNR = Do Not Resuscitate | AD = Advance Directives | H/M/L = Heavy / Medium / Light | ST/LT = Short Term / Long Term



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