



Angel's Loving Care, Inc.

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CLIENT CHECK LIST

It is imperative that the **Client** be completely compatible with the **ALC CareGiver** and that all of their needs are met. **ALC** provides “**Dignity & Quality of Life**” to the **Client**. To that end **ALC** will meet with the **Client** (or responsible party) prior to providing a service in order to evaluate their specific needs and to determine a compatible **CareGiver**.

Name of Client:	
Address of Client:	
Phone(s) Number:	
Birth date of Client:	
Name of party responsible for Client:	
Address of party responsible for Client:	
Phone / contact information of party responsible for Client:	
What is the Client's present condition?	
Does the Client seek a live-in or live-out CareGiver?	
If Live-in what is Client providing for CareGiver (e.g. own room, meals, etc?)	
How many hours a day are required of CareGiver?	
How many days per week are required of CareGiver?	
Can ALC provide a relief CareGiver for day(s) off?	
Is lifting required?	
Does Client require "transfer" assistance?	
Does Client require special equipment e.g., catheters, oxygen?	
Does Client have pets?	
If Yes, do pets need attention of CareGiver?	
Is Client receiving physical therapy?	
What are the Client's special needs?	
Does the Client require medication supervision?	
Is a CareGiver uniform requirement?	
Does the Client smoke?	
Does the Client drink coffee, tea, and alcoholic beverages?	
Other	

Completed by **ALC** representative _____ Date _____