New Client Enrollment Form

Please make sure to complete all required fields as this information helps us to best serve your loved one.

Client Full Name *

First Name | Middle Name | Last Name | Suffix

Client Preferred Name

Client Preferred Gender Pronouns

Marital Status *

Please Select

Please select where we will be providing services *

Please Select

Please select service hours *

- [ ] Part time
- [ ] Full time

Please specify service times and days *

How were you referred to Care Done Right? Or, how did you find out about our services? *

Contact Information

Main Contact Person *

First Name Last Name

Relationship *

Please Select

Emergency Contact 1 *

First Name Last Name

Phone Number *

Area Code Phone Number

Relationship *

Please Select

Emergency Contact 2 *

First Name Last Name

Phone Number *

Area Code Phone Number

Relationship *

Please Select

Health Care Proxy Information

Health Care Proxy Name *

First Name

Health Care Proxy Phone Number *

Area Code | Phone Number

Relationship *

Please Select

Physician Information

Physician First and Last Name *

Name of Hospital *

Phone Number *

Area Code | Phone Number

Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code | Country

Client Information

Current activity status of client? *

- ☐ Self bath/assistance need
- ☐ Dress self
- ☐ Feed self
- ☐ Brush teeth
- ☐ Shave self
- ☐ Toilet
- ☐ Bed pan
- ☐ Urinal
- ☐ Other

Current physical status of client? *

- ☐ Ambulation-independent/assistance-needed
- ☐ Bed to chair
- ☐ Walking
- ☐ Stairs
- ☐ Wheel chair
- ☐ Crutches
- ☐ Cane
- ☐ Bed rest
- ☐ Other

Client's method of communication *

- ☐ Verbal
- ☐ Nonverbal

Language(s) spoken *

Language(s) understood *

Client Medical History

Check if client has been diagnosed with any of the following: *

- ☐ Diabetes
- ☐ Hypertension
- ☐ Seizures/Epilepsy
- ☐ Heart Disease
- ☐ Cancer
- ☐ Thyroid Issues
- ☐ Blood Disorder
- ☐ Anemia
- ☐ Asthma
- ☐ Allergies
- ☐ Hepatitis
- ☐ Kidney Problems
- ☐ HIV Exposure
- ☐ Liver Problems
- ☐ Tuberculosis (TB)
- ☐ Urinary/Bladder Problems
- ☐ Pelvis/Back Problems
- ☐ Stomach/Digestive Issues
- ☐ Skin Disorders
- ☐ Bladder Infection
- ☐ Kidney Infection
- ☐ Severe Headaches
- ☐ Ear/Hearing Problems
- ☐ Eye/Vision Problems
- ☐ Vascular Issues (varicose veins, blood clots, etc.)
- ☐ Hemorrhoids
- ☐ None
- ☐ Other

Describe any checked boxes here

Please list all allergies or sensitivities *

Emotional/Psychological History

Please check if the client has ever been diagnosed or suspected of having any of the following: *

- ☐ Depression
- ☐ Bi-Polar Disorder
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Delusions
- ☐ Paranoia
- ☐ Psychosis
- ☐ Anorexia
- ☐ Bulimia
- ☐ PTSD
- ☐ None
- ☐ Other

If you indicated any of the above conditions, please describe below

Social History/ Diet and Nutrition

Smoking Status *

Please Select

Nutrition *

Example: Vegan or Sugar Free

Exercise Habits *

Sleep Habits *

Hobbies *

Residential Information

Please inform us where the client will be located for services

Nursing Home

Nursing Home Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Nursing Home Contact Person

First Name | Last Name | Position/Title

Nursing Home Contact Phone Number

Area Code | Phone Number

Room Number

Residence

Address

Street Address

Street Address Line 2

Payment/Billing Information

Responsible Financial Party Name *

First Name Last Name

Billing Email *

example@example.com

Billing Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

There will be additional charges for the following: Holidays, COVID, and Late Payments; Weekends *

◯ Check here that you understand and agree to these terms

We accept the following payment methods, please select your preferred payment method *

☐ Check
☐ Zelle

All communication and directives go through our management team!

☐ Collette Salomon-Morgan, CEO; 857-294-6883
☐ Ashley King, COO

Submit Application:

By clicking the submit button below, I hereby agree to Care Done Right, LLC terms and conditions, and policies and procedures.
I also understand that it is my responsibility to keep such information current and accurate by updating it as often as necessary and informing Care Done Right, LLC.
I further understand and accept Care Done Right, LLC financial agreement and policies.
"I certify that the statements made by me on this application are true and complete to the best of my knowledge and are made in good faith. I understand that if I knowingly make any misstatements of fact, I am subject to disqualification, dismissal, or other action pursuant to agency policy and procedure, and subject to criminal penalties as prescribed by law."

Name *

First Name Last Name

Today's Date *

Month Day Year