Admission Sheet

Please answer all questions fully

Date:
Account Number:

Cantys Helping Hands
Home Care Services, LLC

4015 8th Street
Baltimore, MD 21225
Phone: (410) 449-0244
Email: cantyshelpinghands@gmail.com

Patient					
Name (Last, First, MI)	Birthdate	Age	Home Phone	Cell Phone	Sex
Mailing Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Services Needed:	Service Hours Needed:						
☐Respite Care ☐ Personal Care ☐ Household & Family Support Services	☐ Sunday Time:____	☐Mondays Time:_____	☐Tuesdays Time:_____	☐Wednesdays Time:_____	☐Thursdays Time:_____	☐Friday Time:_____	☐Saturday Time:____

Responsible Party					
Name (Last, First, MI)	Birthdate	Age	Home Phone	Cell Phone	Sex
Address	City	State	Zip Code	Marital Status	
Employer	City	State	Zip Code	Work Phone	

Primary Provider	**Address**	**Phone**	**Fax**

Primary Insurance Company	Subscriber's Name	Relationship	Policy Number/Group #

Emergency Contact Information			
Contact Name	Relationship	Primary Phone Number	Secondary Phone Number

Please List All Medical Conditions, Diagnoses, and Medications

Please List Specific Daily Needs

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicaid), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: ____Date: ___________________________
(Signature of insured or authorized person, patient, or parent if minor)