



## SERVICE INTAKE FORM

**Insured Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Alternate Telephone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Country of Origin/primary language: \_\_\_\_\_

**Insurance Information:**

Insurance Company: \_\_\_\_\_ Name of Adjuster: \_\_\_\_\_  
 Telephone of Adjuster: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Company Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Policy/Claim Number: \_\_\_\_\_ Date of Loss: \_\_\_\_\_  
 Name of **Occupational Therapist:** \_\_\_\_\_ Compant of O.T. (if any): \_\_\_\_\_  
 Telephone of O.T.: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_

**Form One Monthly Allowance for Attendant Care:**

Date: \_\_\_\_\_ Amount \$: \_\_\_\_\_

**Form One Monthly Allowance for Housekeeping:**

Date: \_\_\_\_\_ Amount \$: \_\_\_\_\_

Attendant Care Daily Duties to be Performed:	

Housekeeping Duties to be Performed:	

**Start Date:** \_\_\_\_\_ **Duration of Service:** \_\_\_\_\_

**Time and Dates Services to be Provided:**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Times</b>							

