Family Alliance of WNY LLC Client Questionnaire

Date : _____

Client Information:

First Name: _____ **Last Name:** _____

Cell Phone: _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Client Advocate:

First Name: _____ **Last Name:** _____

Cell Phone: _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

What are you looking for in a caregiver: _____

_____

_____

Days and hours needed: _____

_____

Rate of Pay: _____

Pay agency or private: _____

Duties Expected: _____

_____

_____

Health Issues: _____

_____

_____

Allergies: _____

_____

_____

Dietary Restrictions: _____

_____

_____

Family Alliance of WNY LLC Caregiver Questionnaire

Date : _____

First Name: _____ **Last Name:** _____

Cell Phone: _____ **Email:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Certifications: _____

_____

_____

Expected Pay Rate: _____

Availability (Days and Times): _____

_____

How far are you willing to travel: _____

_____

_____

Do you have transportation: _____

References: _____

_____

_____

Experience as a caregiver: _____

_____

_____

_____

_____