



FAMILY ALLIANCE OF WNY LLC

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Tel: (716) 948-4848

Client Questionnaire

Client Information:

Date : _____

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: _____
