

**INQUIRY FORM**

Contact Name \_\_\_\_\_

Party's Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Zip \_\_\_\_\_

Day Phone \_\_\_\_\_

Day Phone \_\_\_\_\_

Night Phone \_\_\_\_\_

Night Phone \_\_\_\_\_

When are you interested in relocating?

\_\_\_\_\_

Are you interested in Assisted or Independent Living?

\_\_\_\_\_

General Health Status?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What assistance will be needed?

Wheelchair-Assistance with transferring

Walker

Assistance with ambulation

Incontinent

Assistance with bathing

Assistance with Medications

Diabetic Diet

Stress Incontinence

Blindness

Special Diet

Assistance with Bathing, Dressing,  
Transferring, Activities of daily Living etc...

Hospice/Respite

Date \_\_\_\_\_

\_\_\_\_\_

Signature