CARE 365
A TOV CARE HOME HEALTH SERVICES COMPANY

OUR LOCATIONS
2733 E. 12TH STREET, BROOKLYN, NY
38-27 98TH STREET, CORONA, NY
175 MAIN STREET, WHITE PLAINS, NY
300 N MAIN STREET, SUITE 301, SPRING VALLEY, NY

1.833.CARE365 // P: 718.627.7050
www.Care365.care // intake@care365.care

HOMECARE: Always Available

CONSUMER APPLICATION FOR CDPAP SERICES

To be completed by the Consumer/ Parent / Guardian / Designated Representative

CONSUMER INFORMATION

Last Name:	First Name:	Middle Name:	Application Date:
Address:	City:	State:	Zip:
Social Security Number:	Date of Birth:	Age:	Gender:
Email:	Home Number:	Cell Number:	

PARENT / GUARDIAN / DESIGNATED REPRESENTATIVE INFORMATION (IF APPLICABLE);

Last Name:	First Name:	Relationship to Consumer:
Email:	Home Number:	Cell Number:

MEDICAID INSURANCE INFORMATION

Medicaid Managed Care Plan:	Managed Insurance Member ID:	Medicaid Member ID:
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:

SECONDARY INSURANCE INFORMATION (IF APPLICABLE);

Secondary Insurance Plan:	Secondary Insurance Member ID	
Policy Holder Last Name:	Policy Holder First Name:	Policy Holder Date of Birth:

PHYSICIAN AND DIAGNOSIS INFORMATION

Physician Name:	Physician Address:	
Physician Phone Number:	Physician Fax Number:	Physician Email Address:
Diagnosis Code:	Secondary Diagnosis:	Doctor Assigning Diagnosis:

OTHER INFORMATION

How did you hear about our services? (Check One) ☐ Online research ☐ Email ☐ Sister Agency ☐ Other

Name of Personal Assistant? What is the Consumer's relationship with this person?

Consumer / Parent / Guardian / Designated Representative: _____

Consumer / Parent / Guardian / Designated Representative Signature: _____