FLOBERT, INC.

HEALTH CARE SERVICES

📍 8727 Carved Stone Lane, Richmond, TX 77407
📞 832-945-3946 | ✉ info@flobertinc.com
🌐 www.flobertinc.com

APPLICATION FORM

FLOBERT HEALTHCARE SERVICES, INC.

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HEALTH CARE SERVICES

THE HEART OF COMPASSIONATE HOME HEALTHCARE

📤 Submission Instructions

✅ *Submit the completed form via:*

📧 **Email:** info@flobertinc.com

💬 **Live Chat:** www.flobertinc.com

📍 **In-Person:** 8727 Carved Stone Lane, Richmond, TX

Please complete this form to request care for yourself or a loved one.
All information is strictly confidential.

🖋️ SECTION 1: APPLICANT INFORMATION

- **Full Name:** _____
- **Date of Birth:** ___ / ___ / _____
- **Gender:** □ Male □ Female □ Other
- **Home Address:** _____
- **City:** _____ **State:** _____
- **ZIP Code:** _____
- **Phone Number:** _____
- **Email Address:** _____
- **Preferred Contact Method:** □ Call □ Email □ Text
- **Applying for:**

□ Myself □ A Family Member □ A Friend

- **If applying for someone else, provide:**

Full Name of Patient: _____

Relationship to Patient: □ Parent □ Spouse □ Child □ Other: _____

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THANK YOU FOR YOUR INFORMATION

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🛠️ SECTION 2: SELECT REQUESTED SERVICES

(*Check all that apply)*

□ **Community Attendant Services (CAS) –** Non-medical personal care
□ **Primary Home Care (PHC) –** Daily living assistance
□ **Community-Based Alternatives (CBA) –** In-home, foster home, or assisted living support
□ **Family Care (FC) –** Non-medical, in-home support
□ **Personal Care Services (PCS) –** Care for children & young adults under 21
□ **Private Pay Services – Fl**exible home healthcare options
□ **Other (Please Specify):** _____

📋 SECTION 3: MEDICAL INFORMATION & ASSISTANCE NEEDS

- **Primary Diagnosis (if applicable):** _____
- **Secondary Diagnosis (if applicable):** _____
- **Current Medications: □ Yes □ No**
  - If yes, list medications: _____
- **Do you need assistance with (check all that apply)?**

□ Personal Hygiene □ Grooming □ Dressing □ Bathing
□ Mobility □ Meal Preparation □ Medication Reminders
□ Light Housekeeping □ Companionship □ Other: _____

- **Do you have any allergies? □ Yes □ No**
  - If yes, specify: _____
- **Primary Care Physician:** _____
- **Physician's Phone Number:** _____

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📝 SECTION 4: EMERGENCY CONTACT INFORMATION

- **Full Name:** _____
- **Relationship:** □ Parent □ Spouse □ Child □ Other
- **Phone Number:** _____
- **Email:** _____

📜 SECTION 5: LEGAL CONSENT & AGREEMENT

- **Consent for Services:**

I, (**),** hereby request and consent to receive healthcare services provided by **Flobert Healthcare Services, Inc.** I understand that:

- All information provided is accurate and truthful.
- Services are subject to assessment and eligibility verification.
- My rights and privacy will be respected in accordance with HIPAA regulations.
- I may withdraw consent at any time with written notice.

- **Signature of Applicant/Guardian:** _____
- **Date:** ___ / ___ / _____
- **Witness (if applicable):** _____
- **Date:** ___ / ___ / _____

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_____

Signature

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