

Vital Health Home Care - Care Assessment & Service Request

Blank printable office copy. Complete only sections that apply. Attach supporting records separately.

Privacy and coverage notice: Do not email protected health information through ordinary email. Submission does not guarantee coverage, authorization, employment, service availability, or fulfillment. Payer policy and product-specific requirements control. Call 911 for emergencies.

Person completing form	_____
Relationship to the person needing care	_____
Legal authority details	_____ _____
Submitter full name	_____
Phone number	_____
Email address	_____
Person needing care	_____
Full legal name	_____
Date of birth	___ / ___ / ____
Street address	_____
County	_____
Phone number	_____
Preferred language	_____
Accessibility or communication needs	_____
Services requested	_____
Requested services	_____
Details of activities of daily living assistance needed	_____ _____
Respite care schedule and preferred coverage times	_____
CAP program details	_____ _____
Case manager name	_____
Case manager phone number	_____
Prescriber or physician order information	_____
Requested skilled nursing tasks	_____
Care needs and schedule	_____
Days care is needed	_____
Preferred care start time	_____
Preferred care end time	_____
Preferred care start date	___ / ___ / ____
Current living arrangement	_____
Mobility and transfer assistance needed	_____
Fall risk	_____

VITAL HEALTH SERVICES, LLC

Vital Health Home Care | 7048 Knightdale Blvd., Suite 101, Knightdale, NC 27545 | Phone (919) 679-3022 | Fax (888) 398-8099

Allergies or sensitivities	_____
Infection-control or isolation concerns	_____ _____
Behavioral, safety, or home access considerations	_____
Pets or smoking in the home	_____
Equipment used in the home	_____
Additional care details	_____ _____
Payment pathway	_____
Payment / coverage pathway	_____
Insurance / member ID	_____
Plan name	_____
Case manager name	_____
Organization	_____
Phone	_____
Fax	_____
Authorization status	☐ _____ ☐ Other: _____
Current providers and discharge information	_____
Primary clinician name	_____
Hospital or facility name	_____
Discharge date	___ / ___ / ___
Care coordinator name	_____
Consent and attestation	_____
I authorize Vital Health to contact me regarding this request	_____
I authorize Vital Health to verify benefits and obtain service authorization as needed	_____ _____
I authorize communication with listed providers and case managers for care coordination	_____
Notice of Privacy Practices	_____
Date	___ / ___ / ___
Submit Secure Request	_____
Secure document uploads	☐ Attached ☐ To follow ☐ Not applicable
Insurance card	_____
Authorization or service plan	_____
Physician order	_____
Discharge documents	☐ Attached ☐ To follow ☐ Not applicable
Nursing plan	_____
Other supporting records	_____

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I certify that the information provided is accurate and complete to the best of my knowledge.	_____
Typed signature (full legal name)	Signature: _____

Office use only

Date received	
Intake staff	
Missing documentation follow-up	
Status / reference number	