Service Intake Form

(Insurance, Occupational Therapists, and Physiotherapists)

VERSATILE CARE

20 Steelcase Rd. W., Unit 1F Markham, ON L3R 1B2

(905) 604-8199

Insured Information

Last Name _____ Given Name _____

Address _____ City _____ Province _____

Postal Code _____ Telephone _____ Alternate Telephone _____

Insurance Information

Insurance Company _____ Name of Adjuster _____

Telephone of Adjuster _____ ext. _____ Fax _____

Company Address _____ City _____ Province _____

Postal Code _____ Policy/Claim Number _____ Date of Loss _____

Name of Occupational Therapist _____

Company of O.T. (if any) _____ Address _____

City _____ Province _____ Postal Code _____

O.T. Telephone _____ ext. _____ Fax _____

Alternate Telephone _____ Other Contact Info _____

Form One Monthly Allowance for Attendant Care: Date _____ Amount $_____

Form One Monthly Allowance for Housekeeping : Date _____ Amount $_____

Attendant Care Duties to be Performed:

_____

_____

_____

Housekeeping Duties to be Performed:

_____

_____

_____

Start Date: _____ **Duration of Service:** _____

Times and Dates Service is to be Provided:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Times							