SUNSPOT
MEDIA & BUSINESS LAW

CLIENT INTAKE FORM

Nursing Home Neglect & Abuse Intake

Neglect, abuse, or injury of a resident in a nursing home, assisted living, or care facility

PERSON COMPLETING THIS FORM

First Name | Last Name | Relationship to Resident

Mobile Phone | Alternate Phone | Email Address

Mailing Address | City / State / Zip

Your legal authority for the resident

- ☐ Power of Attorney
- ☐ Legal Guardian
- ☐ Personal Representative
- ☐ Spouse
- ☐ Adult Child
- ☐ Other / None Yet

Do you have documents establishing that authority (POA, guardianship, letters)? ☐ Yes ☐ No

RESIDENT INFORMATION

Resident First Name | Resident Last Name | Date of Birth

Social Security No. | Gender | Date Admitted to Facility

Resident's current status

- ☐ Still in facility
- ☐ Discharged
- ☐ Transferred
- ☐ Hospitalized
- ☐ Deceased

If deceased, Date of Death | Cause of Death (if known)

FACILITY INFORMATION

Facility Name | Facility Phone

Facility Address | City / State / Zip

Administrator / Director (if known) | Parent Company / Owner (if known)

Type of facility

- ☐ Skilled Nursing
- ☐ Assisted Living
- ☐ Memory Care
- ☐ Rehabilitation
- ☐ Residential Care
- ☐ Other

Nursing Home Neglect & Abuse Intake

Neglect, abuse, or injury of a resident in a nursing home, assisted living, or care facility

NATURE OF THE HARM

Type of harm (check all that apply)

- ☐ Pressure ulcers / bedsores
- ☐ Falls / fractures
- ☐ Malnutrition / dehydration
- ☐ Medication errors
- ☐ Infection / sepsis
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional / verbal abuse
- ☐ Wandering / elopement
- ☐ Unsanitary conditions
- ☐ Financial exploitation
- ☐ Wrongful death
- ☐ Restraint injury
- ☐ Other

Date Harm Occurred / Discovered

Who Discovered It

Describe what happened in your own words

INJURIES & MEDICAL TREATMENT

Injuries sustained by the resident

Was the resident hospitalized as a result? ☐ Yes ☐ No

Hospital / Treating Facility

Treating Physician

Current medical condition of the resident

REPORTING & RECORDS

Was the harm reported to facility staff or management? ☐ Yes ☐ No

Reported To (name / title)

Date Reported

Was a complaint filed with the State or Long-Term Care Ombudsman? ☐ Yes ☐ No

Nursing Home Neglect & Abuse Intake

Neglect, abuse, or injury of a resident in a nursing home, assisted living, or care facility

Was Adult Protective Services contacted? ☐ Yes ☐ No

Were police contacted? ☐ Yes ☐ No

Do you have photographs of the injuries or conditions? ☐ Yes ☐ No

Do you have copies of medical or facility records? ☐ Yes ☐ No

RESIDENT'S BASELINE & CARE NEEDS

Pre-existing conditions and diagnoses

Mobility before the harm

☐ Independent ☐ Cane / Walker ☐ Wheelchair ☐ Bedridden

Cognitive status

☐ Alert / Oriented ☐ Mild impairment ☐ Dementia / Alzheimer's ☐ Non-verbal

PAYMENT & WITNESSES

Who pays for the resident's care

☐ Private pay ☐ Medicare ☐ Medicaid

☐ Long-term care insurance ☐ VA ☐ Other

Staff members involved and any witnesses (names / roles)

Are you currently represented by another attorney for this matter? ☐ Yes ☐ No

Additional information you want us to know

ACKNOWLEDGMENT

Completing this form does not create an attorney-client relationship. It is used to evaluate a potential matter and is kept confidential.

Client / Representative Signature

Date

Staff Member Completing Intake

Date