



AMERICAN SENIOR SERVICES INCORPORATED

AGENCY INTAKE FORM

Date: _____

Is your agency a: Franchise Branch Independent?

Corporation Name: _____

DBA: _____

Office Address: _____ City: _____ ST: ___ Zip: _____

Billing Address: _____ City: _____ ST: ___ Zip: _____

Main Contact Name: _____ Title: _____

Office Phone: _____ Cell Phone: _____ Fax: _____

Email: _____ Email: _____

Are you caregivers: Employees or Independent Contractors (1099)

Hourly Rate for Companion type of Care:

Standard: _____ Weekend: _____ Holiday: _____ Minimum Hours: _____

Hourly Rate for Personal type of Care:

Standard: _____ Weekend: _____ Holiday: _____ Minimum Hours: _____

List of Counties Serviced: _____

List of Zip Codes Serviced: _____