



Coalition of Agencies in Service to the Elderly  
Bio Information Form

Date: **3-15-16**

Name: **Tim Krieger**

Title: **Sales and Marketing**

Agency Name: **Preferred Home Care Inc.**

Complete Mailing Address: **6116 Strauss Rd. Lockport, NY 14094**

Phone: **716-433-6408**

Fax: **716-438-5122**

Email address: **tim@preferredhomecareinc.com**

Website address: **www.**

What age range do you serve? **any**

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A brief description of your position: **Sales and Marketing to gain referrals for home medical equipment.**

A brief description of what your agency does: **Home Health Care equipment provider including the following: Oxygen, CPAP, BIPAP, Nebulizers, Walkers, Rollators, Canes, Compression Stockings, Diabetic Shoes, Basic Orthopedic Bracing, Hospital Beds, Bath Safety, and Mobility Safety etc.**

Please list any other programs your agency provides: