CARE RECEIVER INFORMATION & ASSESSMENT FORM

CARE RECEIVER:

TITLE:_____ FIRST NAME:_____ LAST NAME: _____
(Mr. Mrs. Miss Ms)

ADDRESS:_____

ADDRESS 2:_____ COUNTY:_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: Home_____Cell_____ BIRTHDATE:_____ SEX:_____
(Mo/Da/Yr)

EMAIL:_____

RELIGION:_____ CONGREGATION:_____

HOBBIES/INTERESTS:_____

(FORMER) OCCUPATION:_____

ARE YOU A VETERAN? ____YES ____NO IF YES, WHAT BRANCH?_____

PERSON MAKING REFERRAL:_____ PHONE:_____

RELATIONSHIP TO CARERECEIVER:_____

ASSESSMENT MADE BY:_____ DATE:_____

SERVICES REQUESTED:

_____Transportation
_____Shopping-Grocery
_____Shopping-Retail
_____Visiting
_____Reassurance Calls
_____Respite Care
_____Chores (Laundry, odd jobs)
_____Other:_____
_____Canine Visitor (Circle One)
(Small, Medium, Large)

Details of Service(s) Requested_____

Date for the service to begin? _____

What time of day and day of week to you wish to be served? _____

_____

USES:

_____Cane
_____Walker (size)
_____Wheelchair
_____Oxygen
_____Prosthetics
_____Other
If checked explain:
_____

VEHICLE RESTRICTIONS:

_____Medium
_____Large
_____Van/SUV
_____NO Van/SUV
_____Other
If checked explain:
_____
_____

NEEDS ASSISTANCE:

_____Getting in Car
_____Getting out of Car
_____Walking
_____Other
If checked explain:
_____
_____
_____

CURB LEVEL:

____Curb to Curb
____To Door
____In Door
____Escort

LIVING ARRANGEMENTS:

____Alone
____With Spouse/Family
____In Nursing Home
____Animal(s)

SUPPORT SYSTEM:

____Family ____MOW
____Neighbors ____Therapy
____Friends ____Congregation
____Agencies ____Other

ETHNICITY:

_____African American
_____Asian Pac. Island
_____Caucasian
_____Hispanic
_____Native Amer/Alask/ Hawaiian
_____Other Minorit y

MARITAL STATUS:

____Married
____Divorced
____Widowed
____Single

Explanation of Support System and any current services that are being employed:

_____
_____
_____

Name: _____

FINANCIAL INFORMATION _____PACE _____PACENET _____MEDICAID

1 Person ____$0-$14,950 ____$14,951-$24,950 ____$24,951-$39,900 ____Over $39,901
2 People ____$0-$17,100 ____$17,101-$28,500 ____$28,501-$45,600 ____Over $45,601

HEALTH STATUS

____Vision Loss
_____Glasses
_____Legally Blind – R L
_____Eye Disease
____Hearing Loss
_____Deaf – R L
_____Hearing Aids – R L
____Arthritis
____Cancer
____Depression
____Diabetic
____HBP
____Heart Condition
____Incontinence
____Joint Replacement
____Lung Disease
____Mental Health
____Multiple Sclerosis
____Pacemaker
____Parkinson's Disease
____Prosthetics
____Seizures
____Smoker
____Stroke
____Lifeline
____Cognitive Impairment (Confusion, Memory Loss)_____

Details of Health Status:_____

_____

_____

Do you have a disability? ____Yes ____No If yes, specify:_____

I PREFER THAT THE VOLUNTEER BE _____Male _____Female _____No Preference
_____Non-Smoker
_____Other_____

EMERGENCY CONTACT INFORMATION:
NAME:_____ RELATIONSHIP:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE:_____CELL PHONE:_____
OTHER INFORMATION:_____

NAME:_____ RELATIONSHIP:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
HOME PHONE:_____CELL PHONE:_____
OTHER INFORMATION:_____

I authorize ShareCare and referring agencies to disclose identifying information for the purpose of: 1) Notifying emergency contact(s) in the event of an emergency; 2) Providing medical information to emergency caregivers (if needed); and 3) Sharing information with referral sources and ShareCare Volunteers.

SIGNATURE_____ **DATE**_____

Name: _____

ASSESSOR NOTES

CONDITIONS OF THE HOME

____Clutter ____Smells ____Handrails
____Fall Hazards ____Other ____Steps

EXPLAIN ALL CHECKED ITEMS:

ADDITIONAL LOCATION INFORMATION:

ASSIGNED TO: CONG _____ **VOLUNTEER** _____ **DATE**_____
INTAKE DATE: _____