**People Who Care** New Neighbor Phone Interview

Date: 3/2/2022 **Taken by:** PEGGY

Name:       Phone: home 3 cell

Street:       City      , Zip       Steps to access home? #

Mailing Address if different (PO BOX):

Area/Subdivision:       How long have you lived in the City?

Specific Directions:

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Email address:

Phone interview help was provided by (list who and relationship/Agency):

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| Gender:  F  M | Date of Birth: | Age: |
| Living Situation?  own  rent | | |
| lives alone  Spouse | | |
| Family Member        Roommate | | |
| Does someone smoke in the home or outside the home? No  Yes | | |
| Pets in the home?  Yes No Dog, Cat – Note quantity of each        other | | |

How did you hear about People Who Care?

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| Do you have a Faith affiliation?  Yes Where:       No | | | |
| **Emergency Contacts (name, address and phone numbers, family full address is required)** | | | |
| Name: | | Relationship: | |
| Home # | Cell # | | Work # |
| Address | | | |
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| Name: | | Relationship: | |
| Home # | Cell # | | Work # |
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| Home # | Cell # | | Work # |
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| Name: | | Relationship: | |
| Home # | Cell # | | Work # |
| Address | | | |
| A free Home Safety visit is part of our enrollment it will be done after enrolling in our program.  Additional Notes: | | | |
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| Name:  Mobility & Physical Limitation:  Walker  Walker w/seat  Cane  White Cane | | | |
| Wheelchair, able to self transfer  yes  no.  Power chair, able to self transfer  yes  no | | | |

Portable O2

Post approval requirement for portable O2:

Has prescription for portable O2 that they carry with them in wallet.

Will have prescription faxed to PWC office for file.

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| Medical Conditions: | |
| Hospitalization/Surgery in last 2 years? | |
| Recent falls, how is your balance?:       Do you have a life alert system?  yes  no.  Guardian Alert 911 – check eligibility. | |
| Arthritis:  Rheumatoid? How has this affected your life? | |
| Fibromyalgia | |
| Diabetes  on insulin  oral Medication  Neuropathy, numbness  do you test your blood? | |
| Respiratory  using oxygen  24/7  night | COPD  Asthma |
| Stroke – when       how does this affect your life today  Refer to Stroke Support Group 1st & 3rd Friday @ 10:15-11:30 for both caregiver/survivor  Send contact information to Marianne Simpson [completed date      ] | |
| Heart Problems        Heart Attack – when        Pacemaker  yes  no | |
| Chronic Illness or Injury  Lupus  Chronic Pain  Traumatic Brain Injury | |
| Depression or blue days  yes  no. Discuss our partnership with Senior Peer  yes  no | |
| Disability  Visual  Verbal  Physical        Cognitive | |
| Mental Health  Bipolar  Obsessive/Compulsive Disorder  other       Are you currently  working with a therapist?  yes  no. If WYGC, we need case manager’s name | |

Have you had a diagnosis of Dementia or Alzheimer’s?  yes  no - Note what kind:

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| Hearing loss       Hearing Aids  yes  no Special phone equipment  yes  no |
| Cancer: Type:  In the last year |
| Still being Treated? If yes -  What is your Treatment:  Radiation  Chemotherapy  How are you doing? |
| Back Pain or Injury? |
| Recent joint surgery? knee  hip  shoulder |
| Are you often forgetful? |
| Vision loss  Glaucoma  Macular Degeneration, are you receiving treatment?  yes  no  Cataracts? Are you  Legally blind? Do you have:  Guide Dog  White Cane  Add to Low Vision Course (list support person for class too)  Refer to Low Vision Support Group meeting on Wednesdays |
| Multiple Sclerosis       Did you know: MS support group 2nd Thursdays Prescott VA (see flier) |
| Cerebral Palsy |
| Parkinson’s |
| Epilepsy/Seizures – Frequency |
| Describe what happens: |
| Any additional condition(s) |
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| Temporary Disability?  yes  no |
| Medical Providers |
| Primary Care |
| Specialists |
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| Name:  Medical Insurance: |
| Medicare  Medicare Supplement  AHCCCS  other |
| US Military Veteran? Yes  No  VA Medical Center?  Yes  No If yes, Team Color       Last Four |
| Currently using these Agencies: |
| NACOG Elder Care – Case Manager: |
| Meals on Wheels |
| Housekeeper |
| Home Health Care, Agency Name: |
| Hospice – Agency Name:  Should we provide a referral to any of the above Agencies, which? |
| Who is assisting with transportation/shopping currently?  Are there any vehicles you have trouble getting in & out of? ie. Pickup truck (with a step stool).  Would a Volunteer of the opposite sex be acceptable? Yes  No  Would you like to **get** a wellness call from another neighbor? Yes  No  Would you like to **give** a wellness call to neighbor? Yes  No  We help with technology, would you like help w/your tablet, ph. / computer? Yes  No. Describe what assistance is needed  COVID vaccines?  Yes  No - A few of our Volunteers only assist Neighbors who are. A yes or no answer does not guarantee approval of your application.  Mask mandate for riding in Volunteer’s vehicles – due to our Grants, please review current policies for Mask mandate due to Pandemic. |
| **If you received an evacuation notice for your area, would you be able to evacuate your home and the neighborhood?**  yes  no |
| Approximate Household Income: Note either monthly **or** annual (information for grant applications, AZ Tax Credit) |
| One person – Annual Income       or Couple - Annual Income       or  Monthly: Monthly:  Level 1 under $1120  Level 1 under $1451  Level 2 between $1121 and $1862  Level 2 between $1452 and $2129  Level 3 between $1863 and $2979  Level 3 between $2130 and $3404  Level 4 over $2980  Level 4 over $3405 |

911 Alert eligibility – landline  Yes  No, income  Yes  No

If no family in the area, what assistance do you need from PWC?

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| If family is in the area, please note here what the family can help with and what assistance do you need from PWC? |
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Notes from phone interview:

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**Committee Review**: Date: Click here to enter a date. Decision circle one: Approved to move forward or Declined Why:

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