FAITH IN ACTION

Faith in Action Caregivers, Inc.
Care Receiver Information Form

Date Entered _____
ID #: _____

Person Making Referral/Completing Form

Name: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Receiver Information

Name: _____
Address: _____ City: _____
State: _____ Zip: _____ County: _____
Home Phone: _____ Cell Phone: _____
Birth Date (Month/Day/Year) _____ Sex: Male _____ Female _____
Church or Temple (to which you belong): _____
Location:
City: _____ State: _____ Zip: _____

Directions to Home: _____
_____
_____

Ethnicity:
_____ African American _____ Asian/Pacific Islander _____ Hispanic
_____ Native American/Alaskan/Hawaiian _____ White _____ Other

Living Arrangements:
_____ Lives Alone
_____ Not Alone (Relationship) _____

Services Requested: (Dependent on the availability of a volunteer)
_____ Telephone reassurance phone calls
_____ Transportation
- _____ To medical appointments
- _____ To medical appointments in Pittsburgh
- _____ To medical appointments in Morgantown
- _____ To other places

_____ Errands _____ Respite Care
_____ Friendly Visits _____ Grocery Shopping

Is the Care Receiver low income?
_____ Yes _____ No Source of Income _____

Please complete other side of form

Date Entered _____
ID #: _____

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Mobility:

_____ Cane _____ Walker _____ Wheelchair _____ None

Vision:

_____ Vision Impaired _____ Blind

Medical Conditions:
Does Care Receiver have a medical condition that may affect what a volunteer can do?
_____
_____

Medical reason for requesting help if care receiver is not elderly: _____
_____
_____

Support System:
Emergency Contact: Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: _____ Cell Phone: _____

Neighbor who can check on care receiver in an emergency: _____
Address: _____
Home Phone: _____ Cell Phone: _____

Name of person with key to access care receiver's home: _____
Relationship: _____
Home Phone: _____ Cell Phone: _____

Other agencies providing help _____

Comments:
Does Care Receiver have a pet? _____ If so, what kind? _____
Does Care Receiver smoke? _____ Does Care Receiver prefer assistance from a non-smoker? _____
Hobbies and/or interests: _____
Other Comments: _____

Return form to:
Faith in Action Caregivers, Inc.
38 N 4th St.
Martins Ferry, OH 43935

For questions:
Phone: (304) 243-5420
Fax: (304) 243-5983
www.faithinactionwheeling.org