



**Client Application**

*Interfaith Caregivers offers support to seniors, including those with limited mobility, free-of-charge, helping them to remain independent, as long as it is healthy and safe for both the volunteer and the client.*

Last Name: \_\_\_\_\_ M.I. \_\_\_\_ First Name: \_\_\_\_\_

Maiden Name \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**(Minimum age for services is 60)**

Other name(s) you may have used in the past \_\_\_\_\_

Address: \_\_\_\_\_ (Apt) \_\_\_\_\_ City \_\_\_\_\_ State \_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Religious Affiliation \_\_\_\_\_ Congregation \_\_\_\_\_

Are you a Veteran \_\_\_\_ Yes \_\_\_\_ NO Veteran Family Member \_\_\_\_\_

Active Duty \_\_\_\_ Military Family Member \_\_\_\_\_

How did you hear about Interfaith Caregivers? \_\_\_\_\_

**Services Requested** (Check all that apply)

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Paperwork (mail, bills) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Visiting       | <input type="checkbox"/> Reassurance Calls       |                                      |
| <input type="checkbox"/> Shopping       | <input type="checkbox"/> Respite Care            |                                      |

**Marital Status:** Married \_\_\_\_ Single \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Life Partner \_\_\_\_ Other

**Living Arrangement:** \_\_\_\_ Alone \_\_\_\_ with Spouse or Family Member \_\_\_\_ House \_\_\_\_ Apartment

\_\_\_\_ Assisted Living \_\_\_\_ Other \_\_\_\_\_

**Mobility and Care Needs:** \_\_\_\_ Walking Independently \_\_\_\_ Cane \_\_\_\_ Walker \_\_\_\_ Wheelchair

\_\_\_\_ Home Bound \_\_\_\_ Oxygen

~ Please be aware that Interfaith Caregivers Volunteers cannot provide personal care services such as; dressing, bathing, feeding, or assisting with oxygen. If you have any of these needs, please notify the Interfaith office at 262-376-5362 and they will be happy to refer you to an agency in the area who can help.

**Sensory Perception:**

**Auditory:** \_\_\_ No Problem \_\_\_ Hearing Aid \_\_\_ Right \_\_\_ Left \_\_\_ Both \_\_\_ Written Notes \_\_\_ Other: \_\_\_\_\_

**Vision:** \_\_\_ No Problem \_\_\_ Glasses \_\_\_ Blind \_\_\_ Other: \_\_\_\_\_

**Speech / Communication:** \_\_\_ No Problem \_\_\_ Slurred speech \_\_\_ Sign Language (ASL)  
\_\_\_ Language Barriers \_\_\_ Other: \_\_\_\_\_

**Health and Independence Status:**

What health problems/diagnosis do you have?

\_\_\_\_\_

What everyday activities do you have difficulty doing?

\_\_\_\_\_

**Are you currently enrolled in:** \_\_\_ Health Insurance Plan \_\_\_ Family Care \_\_\_ Community Care  
\_\_\_ WI Forward Health Card \_\_\_ Medicare \_\_\_ Medicaid Other: \_\_\_\_\_

Are you currently receiving assistance from another agency such as the ADRC, Meals on Wheels, etc..?

\_\_\_ Yes \_\_\_ No Please List: \_\_\_\_\_

Do you have a counselor/caseworker? \_\_\_ Yes \_\_\_ No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have a declared or verified disability through Social Security? \_\_\_ Yes \_\_\_ No

**In the Last Year**

Have you had any hospital admissions? \_\_\_ Yes \_\_\_ No

Have you had any recent surgeries? \_\_\_ Yes \_\_\_ No

Have you had any falls? \_\_\_ Yes \_\_\_ No

**Safe Environment Determination**

Does anyone in your home smoke? \_\_\_ Yes \_\_\_ No

Are there pets in the home? \_\_\_ Yes \_\_\_ No

If "yes," how many? \_\_\_\_\_ Type: \_\_\_\_\_

Are there weapons in the home? \_\_\_ Yes \_\_\_ No

If "yes," are the weapons stored and locked? \_\_\_ Yes \_\_\_ No

Do you have any criminal charges pending against you? \_\_\_ Yes \_\_\_ No

Were you ever convicted of a crime? \_\_\_ Yes \_\_\_ No

~ For your safety, Interfaith Caregivers conducts criminal background checks on all perspective clients and volunteers.

**Emergency Contact Information**

1. Name _____	2. Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Relationship _____	Relationship _____
Telephone: Home _____	Telephone: Home _____
Work _____	Work _____
Cell _____	Cell _____
Email _____	Email _____

**For Interfaith’s Grant Writing Purposes, Please Answer the Following**

Ethnicity

<input type="checkbox"/> African/American	<input type="checkbox"/> Native American	<input type="checkbox"/> White/Caucasian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pacific Island	<input type="checkbox"/> Indian
		<input type="checkbox"/> Other _____

Are you low income?  Yes  No

Gender:  Female  Male

**Understanding and Signature**

I understand that Interfaith is an organization based on the good-will of dedicated volunteers, and that a match for service is not guaranteed, although Interfaith will diligently work on finding a volunteer for my specific needs. In addition, the information I have provided on this application is truthful and accurate to the best of my knowledge. I understand that a further review of my application may include a criminal background check conducted by Interfaith Caregivers of Ozaukee County. Furthermore, I understand that providing false information, omitting information, or an unfavorable result of a criminal background check, may result in denial of services from Interfaith Caregivers of Ozaukee County.

\_\_\_\_\_  
*Signature of applicant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of person helping complete application*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print name of person completing application*

**Please return this application to:**

**Ozaukee Nonprofit Center  
Interfaith Caregivers of Ozaukee County  
2360 Dakota Drive  
Grafton, WI 53024**

**Information Provided Is Confidential**

\*For office use only: Date application received: \_\_\_\_\_

Initial phone call date: \_\_\_\_\_

Home assessment scheduled: \_\_\_\_\_