



Client Application

Interfaith Caregivers enables seniors and individuals with disabilities to remain independent in their homes.

Last Name: _____ M.I. ____ First Name: _____

Maiden Name _____ Birthdate: ____ / ____ / ____

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

Address: _____ (Apt) _____ City _____ State ____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Email _____

Are you a Veteran ____ Yes ____ No Veteran Family Member _____ Active Duty Family Member _____

How did you hear about Interfaith Caregivers? _____

<u>Services Requested</u> (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"/> Grocery 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 Caregiver 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: _____

Understanding and Signature

I understand that Interfaith is an organization based on the goodwill of dedicated volunteers, and that a match for service is not guaranteed. However, Interfaith will work diligently to find 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:

**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: _____