VOLUNTEER CAREGIVER PROJECT

PO Box 125, Independence, WI 54747 (715) 985-2391 ext.1205

REQUEST FOR SERVICES

Care Receiver Information

First & Last Name: ____ Today's Date: _________________Home Visit Date: ___/____/___
Address: ____ Gender (*Please circle one*): **M / F** Date of Birth: ____/_____/_______ Telephone: (___) ______-_____ Referral Source: ________________**Annual** household income?______________

REQUIRED FOR STATISTICAL PURPOSES *(if you do not complete the section below, we* ***may not*** *be able to provide a Weekend Food Bag for your child):*

Head of Household First & Last Name (please print): **Birthdate:**

Relationship to applicant(s): **Home/Cell Phone Number:**

Address:

How many individuals are in your household? _______# of Adults _______# of Children

What is your household income? $_____________/Week

Do you rent or own your home? (Please circle): Rent Own

Please list *all* household members below:

First Name	MI	Last Name	Date of Birth	Gender	Military Status	Disability (Yes/No)	Relationship to Head of Household	Race (American Indian, Asian, Black, Pacific Islander, Caucasian)	Ethnicity: Hispanic/ Latino Y/N	Employment Status	Currently enrolled in school? Y/N	Highest Level of Education	Health Insurance (Medicaid, Medicare, Private, Other, None)
1 **Head of Household**													
2													
3													
4													

Signature____**Date**_____/_____/________ ***If you need additional space, please use the back of this sheet. Thank you.**

Services Requested (number in order of greatest need 1= strongest)

Light Housekeeping	Telephone Visiting	Friendly Visiting
Respite Care	Errands	Other
Meal Preparation	Transportation	
Shopping	Socialization	

Present Providers of Assistance (Agency, Neighbor, Family, Other)

Name/Title	Agency/Relationship	Telephone	Dates (To/From):

Emergency Contact Information

	Name:	Phone Number:
Primary Care Physician/Doctor:		
Dentist:		
Preferred Clinic/Hospital:		
Health Insurance Provider:		

Health Status Information

Smoker: ____ Yes ____No Pets: ____________________________________

Mobility: ____

❑Walker ❑Wheelchair ❑Drives own car

❑Cane ❑Scooter

Cognitive Function Abilities:

- ❑ Able to understand own needs and ask for help
- ❑ Able to understand and follow verbal instructions
- ❑ Able to understand and follow written instructions

Physical Health: Do you have or have you had any of the following health problems?	❑Allergies ❑Arthritis ❑Cancer ❑Dementia/Alzheimer's ❑Diabetes ❑Hearing Problems ❑Stroke ❑Orthopedic ❑High Blood Pressure ❑Incontinence ❑Vision Problems ❑Kidney Disease ❑Neurological/Balance ❑Heart/Respiratory ❑Mental Health Issues (Please specify):_______________ _________________________ ❑Other: (Please Explain) ____ _ Recent Hospitalizations/nursing home stays: _______________________________________
Directions to Home: ____ ____ ____________	Additional Comments: ____ ____ ____ ____

PHOTO RELEASE

I have no objection to the use of my picture by RSVP for the specific purpose of publicity, public relations, or educational promotion, providing it is legitimately published with discretion.

❑ **AGREE** ❑ **DISAGREE**

SCREENING INFORMATION

Do you or does any member of your household have criminal charges pending against you or were you ever convicted of a crime (not including traffic violations) anywhere, including federal, state, local, military, and tribal courts?
If yes, list each crime, when it occurred/date of conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of convictions, a copy of the criminal complaint, or any other relevant court or police documents.

____

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I understand that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information will result in denial or termination of services.

Personal References: ***(Please print clearly and list complete addresses).***

1-Name:		Relationship:
Street Address:		
City:	State:	Zip Code:
Phone Number:		
2-Name:		Relationship:
Street Address:		
City:	State:	Zip Code:
Phone Number:		

Authorization: I understand the screening requirements mentioned above, and authorize RSVP Volunteer Caregivers Project to proceed with the criminal background check and to contact my personal references. (Please note: **ALL** household members are subject to a background check and need to sign below).

(Applicant signature) (Date)

(Household Member Signature) (Date of Birth) (Date)

(Household Member Signature) (Date of Birth) (Date)