



# VOLUNTEER CAREGIVERS

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



## REQUEST FOR SERVICES

### Care Receiver Information

Name: \_\_\_\_\_ Referral Source: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: **M / F** Please circle one

Home Visit Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Are you a Veteran?  YES  NO

Date of Birth: \_\_\_\_\_ What is your **annual** household income? \_\_\_\_\_

### Family or Significant Other Information

Marital Status: M S W D Spouse's Name: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

List anyone *else* living in your home in the space provided below (If applicable).

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\_\_\_ Light Housekeeping    \_\_\_ Telephone visiting    \_\_\_ Information/Referral

\_\_\_ Respite Care    \_\_\_ Errands    \_\_\_ Friendly Visits

\_\_\_ Meal Preparation    \_\_\_ Transportation    \_\_\_ Yard Chores

\_\_\_ Shopping    \_\_\_ Minor Home Repair    \_\_\_ Other

\_\_\_\_\_

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

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

**Emergency Contact Information**

Primary Care Physician/Doctor: \_\_\_\_\_ Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dentist: \_\_\_\_\_

Preferred Clinic/Hospital: \_\_\_\_\_

**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
- Other: (Please Explain) \_\_\_\_\_

Recent Hospitalizations/nursing home stays: \_\_\_\_\_

Directions to Home: \_\_\_\_\_

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).

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(Applicant signature) (Date)

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

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