

***Faith in Action* Volunteers**
CARE RECEIVER INFORMATION AND
ASSESSMENT FORM



F A I T H
I N A C T I O N

V O L U N T E E R S

Broome County Council of Churches
3 Otsenigo St., Binghamton, NY 13903
Phone: 607-724-9130 Fax: 607-724-9148

CONSENT FOR SERVICES:

I, _____, give permission to the Broome County Council of Churches, *Faith in Action* Volunteers (FIA):

- To conduct this assessment to determine program ability to assist with tasks I have requested.
- If eligible, to assist me with the tasks I have requested.
- To contact any of the persons listed on page 4 on my behalf for emergency purposes, including my primary physician, or agencies from which I am currently receiving services.

I understand that *Faith in Action* Volunteers may not be able to meet my requests.

Date

Signature of Care Receiver

Signature of Assessor

CARE RECEIVER INFORMATION & ASSESSMENT FORM

Referral made by: _____ Phone: _____

Relationship to Care Receiver: _____

Assessment made by: _____

IDENTIFICATION / CONTACT INFORMATION

SS# (last four digits) _____

Name: (Mr./Mrs./Ms./Miss) First: _____ Last: _____

Address: _____ Single- family
_____ Apartment: # _____ Or _____ Floor

Directions: _____

Phone: Home # _____ Cell # _____ Email: _____

D.O.B. _____ **Gender:** Male Female

Religious Affiliation: _____ **Congregation:** _____

Ethnicity: Caucasian African American Hispanic Native American Other _____

Smoker: Yes No Other Smokers: Yes No Pets: Yes No

Describe: _____

NEEDS PROFILE/SERVICES REQUESTED

- | | | |
|--|--|--|
| <input type="checkbox"/> Visiting | <input type="checkbox"/> Reassurance Calls | <input type="checkbox"/> Healthier-Weight Management |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Paperwork | <input type="checkbox"/> Healthier-Grocery Shopping |
| <input type="checkbox"/> Respite Care | <input type="checkbox"/> Chores(seasonal) | <input type="checkbox"/> Healthier Meal Planning |
| <input type="checkbox"/> Shopping w/list | <input type="checkbox"/> Minor Repairs | <input type="checkbox"/> Healthier Exercise Planning |
| <input type="checkbox"/> LtHousekeeping | <input type="checkbox"/> Meal Assistance | <input type="checkbox"/> Other _____ |

Availability to Receive Services: No Preference

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Morning Afternoon Evening

CARE RECEIVER DETAILS

Caregiver gender preference: Female Male No Preference

Mobility: Needs assistance to walk Cane Walker Wheelchair Bed Bound

Able to climb stairs independently: Yes No

Able to access vehicles: Small Sedan Large vehicle SUV-Truck Mini Bus

Vision: Wears Glasses Legally Blind Fully Blind

Auditory: Hearing Loss Wears Hearing aid(s)

Assistive Devices: _____ LifeLine

Health Status: Obese Overweight Underweight Uses Oxygen

Diabetes Insulin Seizure Disorders Congestive Heart Failure

Treatment for other physical or mental health conditions: Yes No

If yes describe: _____

Signs of dementia or inability to understand (describe): _____

Living Arrangements:

Care Receiver Lives: Alone w/Spouse / Family Nursing Home Assisted Living

Other (Describe) _____

Physical Premises:

Fire Hazards: Yes No If Yes, describe _____

Clean: Yes No Cluttered: Yes No

Smoke Detector: Yes No

Do you have an emergency exit plan? Yes No

Imminent Dangers: _____

CURRENT SUPPORT SYSTEMS

Financial Resources: Pension Social Security SSI/D Other _____

Emergency and Personal Contact Information and Family Members:

Name	Type	Address	Phone	Emergency Contact	Add to BCCC Mailing List
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Registered with Office for the Aging? Yes No STIC: Yes No

CASA: Yes No Church/Synagogue: Yes No Name: _____

Other: Yes No

Services Received: _____

Primary Physician:

Name: _____ Phone: _____

Hospital of affiliation or choice: _____

RECOMMENDATIONS AND REFERRALS: (Please include any other agencies involved in providing assistance to the care receiver)
