FAITH
IN ACTION

Care Receiver & Assessment Form

Broome County Council of Churches
3 Otseningo 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

Referral Information

Referral made by: _____

Phone: _____ E-mail address: _____

Relationship to Care Receiver: _____

Assessor Information

Assessment made by: _____

Phone: _____ E-mail address: _____

Care Receiver Information

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

Address: _____ □ Single- family
_____ □ Apartment: #____ or ____ Floor

Directions: _____

_____

Phone: Home # _____Cell # _____Email:_____

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

Congregation_____ Religion_____

Ethnicity: □Caucasian □African American □Hispanic □Native American □Other _____
Smoker: □**Yes** □**No** Other Smokers: □**Yes** □**No** Pets: □**Yes** □**No**

Describe pets: _____

Services Requested

1. Friendly Visits	**4. Reassurance calls**	**7. Social Connections**	**10. Other (explain)**
2. Transportation	**5. Light Housekeeping**	**8. Grocery Day**	
3. Shop From a List	**6. Paperwork**	**9. Seasonal Chores**	

Days available to Receive Services: □ No Preference

□Monday □Tuesday □Wednesday □Thursday □Friday □Saturday □Sunday
□Mornings □Afternoons □Evenings

Caregiver gender preference: □ Female □ Male □ No Preference

Care Receiver Details

Client Mobility:
Needs assistance to walk: **□Yes □No**
Able to climb stairs independently: **□Yes □No**
Cane: **□Yes □No** Walker: **□Yes □No** Wheelchair: **□Yes □No** Bed Bound: **□Yes □No**
Scooter: **□Yes □No - can** transfer from wheelchair to vehicle: **□Yes □No**

Medicaid Eligible □Y □N

Able to access vehicles: Small Sedan Large Vehicle SUV-Truck Mini-Van

Vision: Wears Glasses **□Yes □No** Legally Blind **□Yes □No** Fully Blind **□Yes □No**
Auditory: Hearing Loss **□Yes □No** Wears Hearing aid(s) **□Yes □No**
Assistive Devices: _____ Life Line **□Yes □No**

Health Status: □ Obese □ Overweight □ Underweight □ Uses Oxygen □ Diabetes □Insulin
□Seizure Disorders □ Congestive Heart Failure □ Special Diet_____

Have you had any treatment for other physical conditions**: □Yes □No**
If yes describe: _____
Have you been treated, diagnosed or shown any symptoms of any mental health conditions? **□Yes □No**
If yes, describe_ _____

ASSESSOR: Any signs of dementia or inability to understand (describe):
_____

Living Arrangements:
Care Receiver Lives: □Alone □ w/Spouse / Family □ Nursing Home □Assisted Living
□Other (Describe) _____
Please describe living situation if other than alone (with who- provide full names or where, provide name of facility)_____

Physical Premises:
Fire Hazards: **□Yes □No**- If Yes, describe_____
Clean: **□Yes □No -** Cluttered: **□Yes □No -** Smoke Detector: **□Yes □No**
CO2 Detector □Yes □ No Do you have an emergency exit plan? **□Yes □No**

Imminent Dangers: _____

Care Receiver Support System

(A) Financial Resources: ☐Pension ☐Social Security ☐SSI/D ☐Other: _____

(B) Family and Emergency Contact Information:

Name & Relationship	Address	Phone	Emergency Contact	Add to BCCC Mailing List
Name_____ **Relationship**_____	_____	_____	☐**Yes** ☐ **No**	☐**Yes** ☐ **No**
Name_____ **Relationship**_____	_____	_____	☐**Yes** ☐**No**	☐**Yes** ☐**No**
Name_____ **Relationship**_____	_____	_____	☐**Yes** ☐**No**	☐**Yes** ☐**No**

(C) Agencies Registered with: Office for the Aging: ____ STIC: ____

Lourdes At Home: _____ UHS @ Ideal: ____ CASA: ___

Other Agency/Organization: _____ Contact Person: _____

Services Received: _____

(D) Primary & Other Physicians:

Primary: _____ Phone: _____

Address: _____

Physician, Other: _____ Phone: _____

Address: _____

Physician, Other: _____ Phone: _____

Address: _____

Hospital of affiliation or choice:

_____

Recommendations and Referrals: (Please include any other agencies involved in providing assistance)

Additional Comments: (Any information useful for volunteers caregivers)

Do you recommend this client for FIA Services ☐ **Yes** ☐ **No**

why or why not?

The volunteers who will be assisting you are caring people who have chosen to serve in a very special way. Therefore, we ask that you follow our program policies when you are with one of our volunteers. Failure to adhere to these policies may result in the termination of your participation with the ***Faith in Action*** **Volunteers Program.**

1. Please call a minimum of 10 days to two weeks in advance of your needs.
2. There may be times when your transportation may be provided via our minivan.
3. For transportation to grocery store or for requests for shopping from a list: (a) maximum twice per month to grocery store closest to your home. (b) Please limit to 5 bags of groceries, no bag to be over 8 lbs.
4. Transportation cancellation: In order to notify the driver in due time, we request a minimum of 24 hours when canceling. Please inform your doctor's office of this policy.
5. Three cancellations within a 6 month period will lead to the re-evaluation of your status in the Program.
6. We ask that you respect the volunteer's time and schedule. Please inform us of the approximate amount of time needed for your request.
7. We expect our clients to treat all volunteers courteously and with respect.
8. We expect that you be fully dressed and ready at the time the volunteer arrives.
9. All inappropriate language and behavior is unacceptable.

I have read and I agree to the policies set forth by ***Faith in Action***.

Name Date

Faith in Action Volunteer's Policies

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Name Date