



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 whom- 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:

<u>Name & Relationship</u>	<u>Address</u>	<u>Phone</u>	Emergency Contact	Add to BCCC Mailing List
Name _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Care Receiver Personal Narrative

Please describe your career/education/professional background:

Please describe your personal interests and/or hobbies (both past and present):

Please tell me about your family history:

Please describe your current social life and/or what you would enjoy adding to your social life:

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**

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.**

10. Please call a minimum of 10 days to two weeks in advance of your needs.
11. There may be times when your transportation may be provided via our minivan.
12. 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.
13. 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.
14. Three cancellations within a 6 month period will lead to the re-evaluation of your status in the Program.
15. We ask that you respect the volunteer's time and schedule. Please inform us of the approximate amount of time needed for your request.
16. We expect our clients to treat all volunteers courteously and with respect.
17. We expect that you be fully dressed and ready at the time the volunteer arrives.
18. All inappropriate language and behavior is unacceptable.

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

Name

Date