Faith in Action Care Receiver Intake

Date

Name:_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Age: ____ **Date of Birth:**_____ **Sex:**_____

Please list any medical problems or physical disabilities: _____

_____

_____

Mobility: Cane_____ **Walker** _____**Wheelchair**_____ **Bedfast**_____

Living Arrangements: alone____ **with spouse** _____ **family** ____ **friend**____

Do you have family living in the area? Yes__**N**__**. Do they provide you with help?**

Describe _____

Are you a Veteran? Yes __ **No**___

Vision Problems: _____

Covid 19 Vaccination: Yes ___ **No** ___ **Covid 19 Booster: Yes** ___ **No** ___

<u>Services requested: (check all that apply)</u>

Visiting____ **Paperwork assistance**_____

Transportation ___ **Brief respite for family caregivers** ___

Shopping ___ **Chores** ____**(non construction)**

Reassurance Calls___ **Other** ___ **(specify)**

Referral Source (if other than the Care Receiver)

Name/Agency _____**Phone:** _____

Relationship to applicant: _____

How did you hear about FIA? _____

Do you receive help/ assistance from anyone or agency in the area? (describe)

_____