Faith in Action Care Receiver Intake

Date______________

Name:____

Address:____

City: ________________________________ State:__________ Zip:_______________________

Age: ____ Date of Birth:_______________ Sex:_____ Phone_____________________

Please list any medical problems or physical disabilities: ___________________________

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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 ___

Services requested: (check all that apply)

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)

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