

# Faith in Action

of the River Cities

\*RID # \_\_\_\_\_ (office use)

## Care Receiver Application For Assistance

Please note that all information contained in this application is considered confidential.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Are you affiliated with a church or faith community? Y \_\_\_ N \_\_\_

If yes, please indicate name \_\_\_\_\_

Who referred you to FIA? \_\_\_\_\_

Name of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_

Name of primary care physician: \_\_\_\_\_

Do you use a cane \_\_\_\_\_ walker \_\_\_\_\_ or wheelchair \_\_\_\_\_ are you bedfast \_\_\_\_\_?

Please list any physical disabilities that limit your mobility: \_\_\_\_\_

Please list any medical problem(s): \_\_\_\_\_

Are there pets in your home? \_\_\_\_\_ Is this a smoke-free household? Y \_\_\_ N \_\_\_

Living arrangements: alone \_\_\_\_\_ with spouse \_\_\_\_\_ with family \_\_\_\_\_ with a friend \_\_\_\_\_

Please indicate any other types of assistance received (i.e. home health, social services, etc.) and the name of the agency (i.e. Hospice). \_\_\_\_\_

Are you a Veteran? Y \_\_\_ N \_\_\_ Do you have vision problems? \_\_\_ Y \_\_\_ N

Describe \_\_\_\_\_

Have you had a Covid 19 Vaccination? 1st dose \_\_\_ 2nd dose \_\_\_ booster \_\_\_ none \_\_\_

## Services Requested

Please check the services or assistance that you need at this time.  
As other needs arise you can call the FIA office

- |  |   |
|--|---|
| 1 ___ visiting                               | 6 ___ paperwork                         |
| 2 ___ transportation                         | 7 ___ limited chores (non construction) |
| 3 ___ respite services for family caregivers | 8 ___ other, please specify _____       |
| 4 ___ shopping                               |   |
| 5 ___ reassurance calls                      |   |

**List the name, address and phone number of two people who can check on you in case of an emergency:**

(Please do not leave blank)

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**Does anyone have an extra key to your home? Y \_\_\_ N \_\_\_**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Person completing this form if other than person to receive care:**

Name: \_\_\_\_\_

Agency or relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I give *Faith in Action* of the River Cities permission to provide a volunteer(s) to assist me,

\_\_\_\_\_, in the areas indicated above.  
(please print name)

\_\_\_\_\_  
Signature of Care Receiver or Legal Guardian (provide documentation) Date: \_\_\_\_\_

RETURN TO: *Faith in Action* of the River Cities  
1900 3rd Ave  
Huntington, WV 25703

If you have any questions regarding this application, please contact the FIA office at 304-697-1274 .