Interfaith Caregivers
Of *Polk County*

Client Application

Personal Info

Name: _____ Application Date: _____
First Last

Other names you have gone by: _____ Birthdate: _____
First Last

Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____ St: _____ Zip: _____

Apartment Name: _____ Apt # _____

Lives in: ☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living

Mailing Address: _____ City: _____ St: _____ Zip: _____

County: _____

Names, relationships and birthdates of all members living in the home
(if more than two please write in Note section on the back of this form.)

1. _____ 2. _____
Name Relationship DOB Name Relationship DOB

☐ Single ☐ Widowed ☐ Married/Partnered _____
Name & Birthdate of Spouse/Partner

We ask the questions below for allergy purposes:

☐ Anyone in the home smoke? ☐ Has Cat(s) ☐ Has Dog(s) Other: _____

Emergency Contact 1: _____
Name Relationship Phone Number

Address: _____
Street City State Zip

Emergency Contact 2: _____
Name Relationship Phone Number

Address: _____
Street City State Zip

Check all that apply:

☐ 60+
☐ Forward Health
☐ SSD/SSI
☐ Disabled
(include SSA Benefit Letter)

☐ IRIS/MTM
☐ Inclusa
☐ VA
☐ MA/Veyo NEMT

☐ Walker?
☐ Rollator?
☐ Oxygen?
☐ Able to get in car alone?

MORE ON BACK ->

What are your greatest concerns? _____

Do you have a specific date you need your first service? (explain below)

_____

Services Requested:

- ☐ Rides – Local Medical
- ☐ Rides – Regional Medical WI or MN
- ☐ Rides - Dialysis/Cancer
- ☐ Rides - Food
- ☐ Deliveries - Grocery
- ☐ Deliveries - Rx
- ☐ Deliveries – Food Shelf Boxes
- ☐ Friendly Home Visits
- ☐ Friendly Phone Calls
- ☐ Run Errands
- ☐ Seasonal Yard Work
- ☐ Rise & Shine (a daily call check-in)
- ☐ Meal Prep
- ☐ Respite Care
- ☐ Books-To-Go
- ☐ Housekeeping
- ☐ Minor Fix-Its

Needs Assessment

Health concerns volunteers should be aware of?

- ☐ Dementia/Memory Loss
- ☐ Developmental Disability
- ☐ Anxiety
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Other

If disabled, what is the nature of your disability? : _____

Would you like a man or a woman as a volunteer? ☐ Male ☐ Female ☐ Either

Please add any additional information you would like to share below. _____

_____

_____

Understanding and Signature

Interfaith Caregivers of Polk County will conduct a background check on all applicants. **Interfaith reserves the right to refuse services to any applicant.** Please be aware that clients must be able to get to and from, in and out, of a vehicle on their own.

I understand that Interfaith is an organization based on the good-will of dedicated volunteers, and that a match for service is not guaranteed, although Interfaith will diligently work on finding a volunteer for my specific needs. In addition, the information I have provided on this application is truthful and accurate to the best of my knowledge. After Interfaith receives your application, we will contact you with a few more questions, helping us understand how we can best provide service.

Signature of Applicant: _____ Date: _____

Office Use Only: Background Check ☐ National ☐ MN ☐ WI ☐ S/O

☐ Assisted Rides ☐ Bloomerang ☐ Client Letter ☐ File Created

☐ Disability Paperwork Received ☐ In Home Evaluation by:_____ Date:_____