



# Request a Volunteer

Date Entered \_\_\_\_\_  
ID #: \_\_\_\_\_

### Receiver Information

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date (Month/Day/Year) \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Church or Temple (to which you belong): \_\_\_\_\_ City: \_\_\_\_\_

### **Directions to Home:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Person Making Referral/Completing Form if not Receiver

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **Ethnicity:**

\_\_\_\_\_ African American \_\_\_\_\_ Asian/Pacific Islander \_\_\_\_\_ Hispanic  
\_\_\_\_\_ Native American/Alaskan/Hawaiian \_\_\_\_\_ White \_\_\_\_\_ Other

### **Living Arrangements:**

\_\_\_\_\_ Lives Alone..... \_\_\_\_\_ Not Alone (Relationship) \_\_\_\_\_

### **Services Requested: (Dependent on the availability of a volunteer)**

\_\_\_\_\_ Telephone reassurance phone calls  
\_\_\_\_\_ Transportation  
\_\_\_\_\_ Medical appointments (Local area)  
\_\_\_\_\_ Medical appointments (Out of local area - Washington, PA,)  
\_\_\_\_\_ Errands  
\_\_\_\_\_ Friendly Visits  
\_\_\_\_\_ Grocery Shopping

### Health Status

Physical Conditions: \_\_\_\_\_ Vision: \_\_\_\_\_  
Hearing: \_\_\_\_\_ Communication: \_\_\_\_\_  
Aids (cane, walker, wheelchair, glasses, hearing aid, etc.): \_\_\_\_\_

### **(individual must be able to transfer from wheelchair to car on own)**

Other Help Being Provided (relatives, friends, agencies): \_\_\_\_\_



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### Support System:

Emergency Contact: Name: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Neighbor who can check on care receiver/has key to home in an emergency:

\_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Comments:

Does Care Receiver have a pet? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

Does Care Receiver smoke? \_\_\_\_\_ Does Care Receiver prefer assistance from a non-smoker? \_\_\_\_\_

Hobbies and/or interests: \_\_\_\_\_

**Referral Information:** How did you hear about Faith in Action? \_\_\_\_\_

\* \* \* \* \*

**Faith in Action is partially funded by grants. Certain demographic information is needed on many grants, so we would ask for your cooperation in providing the following information. Please be assured that all personal information will be kept strictly confidential.**

**Please circle your monthly income:**

	A	B	C	D	E	F
Household Size	Monthly Income 100%	Monthly Income 133%	Monthly Income 150%	Monthly Income 185%	Monthly Income 200%	Monthly Income Over 200%
1	0-930	931-1238	1239-1396	1397-1722	1723-1861	1862+
2	0-1260	1261-1676	1677-1891	1892-2332	2333-2521	2522+
3	0-1590	1591-2115	2116-2386	2387-2943	2944-3181	3182+
4	0-1920	1921-2554	2555-2881	2882-3553	3554-3841	3842+
5	0-2250	2251-2993	2994-3376	3377-4164	4165-4501	4502+
6	0-2580	2581-3432	3433-3871	3872-4774	4775-5161	5162+

Return form to:

Faith in Action Caregivers, Inc.

2350 Main St., Suite 2

Wheeling, WV 26003

For questions:

Phone: (304) 243-5420

Fax: (304) 243-5983

[www.faithinactionwheeling.org](http://www.faithinactionwheeling.org)