FAITH IN ACTION

MINIMUM OF 7 BUSINESSES DAYS REQUIRED FOR REQUEST

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 the 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)
TRANSPORTATON ONLY FOR LOCAL AREA TO INCLUDE Belmont, Ohio and Marshall Counties

_____ Dialysis
_____- Medical appointments
_____ Errands
_____ Grocery Shopping
_____ Hair Appointments

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)

Physical Attributes: Height _____ Weight _____ (needed to help with locating appropriate volunteer)

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: _____

Other Help Being Provided (relatives, friends,agencies): _____

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 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.
156 B Kruger St.
Wheeling, WV 26003

For questions:
Phone: (304) 238-9124
Fax: (304) 905-8256
www.faithinactionwheeling.org