Client Information Intake Form

Thank you for your interest in the Home Away from Home Respite Center. We want to make sure that everyone in our care is safe and secure. This application will provide us with necessary information and will help guide us in planning activities as well as give us clear information in case of an emergency. Thank you for taking the time to fill out the form completely.

Please let us know if you have questions.

**General Information**

Name of Care Receiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First: Middle: Last:

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

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

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Receiver gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Receiver marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Receiver race: [ ] White: [ ] Hispanic: [ ] African American: [ ] Asian:

[ ] American Indian: [ ] Alaskan Native: [ ] Other:

The Care Receiver lives: [ ] Alone [ ] With a Spouse [ ] With a family member

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Name of Primary Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First: Middle: Last:

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

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

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

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Care Receiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver race: [ ] White: [ ] Hispanic: [ ] African American: [ ] Asian:

[ ] American Indian: [ ] Alaskan Native: [ ] Other:

**Emergency Contacts**

If there is an emergency during respite hours, who should we call:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Information:**

Does the Care Receiver have a Power of Attorney: [ ] Yes [ ] No

* If YES, please provide a copy of the POA
* Power of Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Care Receiver have a Do Not Resuscitate (DNR) Request: [ ] Yes [ ] No

* If YES, please provide a copy of the DNR

Does the Care Receiver have a Healthcare Proxy: [ ] Yes [ ] No

* If YES, please provide a copy of the Healthcare Proxy

Does the Care Receiver have a MOLST Form: [ ] Yes [ ] No

* If YES, please provide a copy of the MOLST Form

**Health Insurance Information**

Primary Health Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Public Aid Case #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recipient #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare #: ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List**:

|  |  |
| --- | --- |
| Name of Medication: | Dosage: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
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|  |  |
|  |  |

**Allergies** (both food/drink and medications):

|  |  |
| --- | --- |
| Name of Allergen: | Reaction: |
|  |  |
|  |  |
|  |  |
|  |  |

**Medical/Health History**

**Chronic Illnesses. Please check all that apply:**

[ ] Acid Reflux [ ] Alcoholism [ ] Allergies

[ ] Alzheimer’s [ ] Anemia [ ] Anorexia

[ ] Arthritis [ ] Asthma [ ] Back Problems

[ ] Cancer [ ] Cellulitis [ ] Chronic Constipation

[ ] Chronic Diarrhea [ ] COPD [ ] Chronic Pain

[ ] Colitis [ ] Colostomy [ ] Congestive Heart Failure

[ ] Decubitus Ulcers [ ] Dehydration [ ] Dementia

[ ] Dental Problems [ ] Developmental Disabilities [ ] Diabetes

[ ] Dialysis [ ] Diarrhea [ ] Digestive Problems

[ ] Diverticulitis [ ] Emphysema [ ] Fractures (recent)

[ ] Frequent falls [ ] Gall Bladder Disease [ ] Glaucoma

[ ] Hearing Impairment [ ] Heart Disease [ ] Hiatal Hernia

[ ] High Blood Pressure [ ] High Cholesterol [ ] Hyperglycemia

[ ] Hypoglycemia [ ] Incontinence [ ] Legally Blind

[ ] Liver Disease [ ] Low Blood Pressure [ ] Multiple Sclerosis

[ ] Muscular Degeneration [ ] Osteoporosis [ ] Oxygen Dependent

[ ] Paralysis [ ] Parkinson’s [ ] Pernicious anemia

[ ] Renal Disease [ ] Respiratory Problems [ ] Shingles

[ ] Smelling Impairment [ ] Speech Problems [ ] Stroke

[ ] Swallowing Difficulties [ ] Taste Impairment [ ] Thyroid

[ ] Traumatic Brain Injury [ ] Tremors [ ] Tuberculosis

[ ] Ulcer [ ] Urinary Tract Infection [ ] Visual Impairment

**Please elaborate on any of the above and/or list other important Diagnoses**:

**Fall Risk Factors:**

The care recipient has fallen within the past year: [ ] Yes [ ] No

**Vision:**

Normal: [ ] Yes [ ] No

Wears Glasses [ ] Yes [ ] No

Wears Contact Lenses [ ] Yes [ ] No

Legally Blind: [ ] Left Eye [ ] Right Eye [ ] Both Eyes

**Hearing:**

Normal: [ ] Yes [ ] No

Hearing Impaired in: [ ] Left Ear [ ] Right Ear [ ] Both Ears

Uses Hearing Aids: [ ] Left Ear [ ] Right Ear [ ] Both Ears

Legally Deaf: [ ] Left Ear [ ] Right Ear [ ] Both Ears

**Cognitive/Emotional Status**

**Please check all that apply:**

[ ] Accepts Help [ ] Agitation [ ] Alert

[ ] Anxiety [ ] Articulates Needs [ ] Assertive

[ ] Cares for Others/Things [ ] Confusion [ ] Cooperative

[ ] Critical Life Change [ ] Depression [ ] Diagnosed MH Disorder

[ ] Disruptive Socially [ ] Friendly [ ] Hallucinations

[ ] Healthy Family Attachments [ ] History of MH Treatment [ ] Hoarding

[ ] Impaired Decision Making [ ] Lonely [ ] Member of Community Orgs

[ ] Memory Deficit [ ] Oriented [ ] Physical Aggression

[ ] Problem Behavior [ ] Recent Losses [ ] Self-neglect

[ ] Sense of Humor [ ] Shows Initiative [ ] Sleep problems

[ ] Substance abuse [ ] Suicidal behavior [ ] Suicidal Thoughts

[ ] Verbal Disruption [ ] Other

**Please elaborate on any of the above and/or list other important cognitive or emotional issues**:

**Speech and Communication Abilities**

**Language(s) spoken:** [ ] English [ ] Other- Please Specify

**Speech Abilities:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Most of the Time** | **Occasionally** | **Never** |
| Talks Voluntarily |  |  |  |
| Answers when spoken to |  |  |  |
| Occasional “words search” |  |  |  |
| Difficulty finding the right words |  |  |  |
| Can’t communicate with words |  |  |  |
| Expresses needs with body language |  |  |  |
| Repetitive words/phrases |  |  |  |
| Talks to Self |  |  |  |

**Comments:**

**Situational Orientation**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Most of the Time** | **Occasionally** | **Never** |
| Knows own name |  |  |  |
| Knows date and year |  |  |  |
| Knows environment |  |  |  |
| Can identify objects |  |  |  |
| Knows family members names |  |  |  |
| Knows Personal information (i.e. address, phone number) |  |  |  |
| Knows how to work familiar machines around the house |  |  |  |
| Remembers conversations from the last few days |  |  |  |
| Can handle own financial matters |  |  |  |
| Can conduct their own food shopping |  |  |  |
| Can follow a story or TV show |  |  |  |
| Speaks appropriately (i.e. at the right time, says the appropriate material) |  |  |  |

**Daily Routine**

Please describe what the care recipient can and cannot do in the course of a “typical” day.

(Include dressing, eating, exercise, toileting, medication, and rest periods)

Before Breakfast:

Breakfast:

Before Lunch:

Lunch:

Afternoon:

Before Dinner:

Does the care recipient usually nap during the day? [ ] Yes [ ] No

**Activities of Daily Living**

**Eating:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Transfer:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Mobility:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Toileting:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Personal Hygiene:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Self-Administration of Medications:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Bathing/Dressing:**

Activity Status: [ ] Person does not participate; another person performs all aspects of this task

[ ] Requires continual help with all of most of this task

[ ] Requires intermittent supervision and/or Minimal assistance

[ ] Totally able

**Social Profile of Care Recipient**

Occupation(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fears: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Hobbies/leisure activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coping Styles (lifetime patterns for dealing with things such as anger, stress, etc.):

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

Care Recipient’s Identified Strengths:

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

Care Recipient’s Problem Behaviors:

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

Names of significant relatives/friends (for example, children, grandchildren) and their whereabouts:

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

**Community Support Status**

Does the care recipient have a family, friends, and/or neighbors who helps with care? [ ] Yes [ ] No

Degree of involvement (Type of help/frequency):

Does the care recipient appear to have a good relationship with this individual? [ ] Yes [ ] No

Describe:

**Any additional information which you feel we should know about the care recipient?**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Thank you for taking the time to fill out this form.

When you are finished, please return this form to:

**The Home Away from Home Respite Center**

Center for Community

MacVittie Union 353

1 College Circle

Geneseo, NY 14454

Phone: 585-245-6057