



Care Recipient Assessment

Date of referral _____

How did you hear about our program? _____

Name _____ Birth date _____
(Mr., Mrs., Miss, Ms., Dr.) Last First (Must be age 60+)

Address _____ Phone # _____
_____ Ethnicity _____
Caucasian, African American, Hispanic, Other

Services Requested (check all that apply):

(Services are offered 1 hour per week and at no charge. We do not offer personal care and are not a resource for food, clothing, or financial assistance. All services dependent upon volunteer availability.)

- ___ Caring Companionship
- ___ Respite (relieve family care giver – offered 2 hours weekly)
- ___ Transportation to medical appointments
- ___ Minor home repairs (Explain below exactly what repairs are requested)
- ___ Wheelchair ramp construction
- ___ Grocery shopping FOR care recipient
- ___ Budget management assistance/Letter writing
- ___ Light housekeeping
- ___ Telephone reassurance

Repair Request Details:

___ living alone ___ living with spouse ___ living with family member

Name of person with whom you live: _____

Mobility Aids: ___ cane ___ walker ___ wheelchair ___ bed bound

Sensory Aids: ___ glasses ___ dentures ___ hearing aid

Sensory problems: (vision, hearing, swallowing, chewing) _____

Please list your diagnosed illness(es): _____

Are you a military Veteran? _____ Are you the widow of a military Veteran? _____

Do you or your care giver smoke? ____ yes ____ no

Do you have a pet? ____ yes ____ no

If "yes", specify what kind of pet(s): _____

Have you (the care receiver), a care giver, or any other resident of the home ever been charged with or convicted of a misdemeanor or felony? ____ yes ____ no

If "yes", please explain: _____

Is English the primary language? ____ yes ____ no (please indicate language) _____

Would a volunteer of the opposite sex of the client be acceptable? ____ yes ____ no

Support System:

Emergency Contact _____
Name Relationship

Address Phone: Day Evening

What other types of assistance/support do you receive?

____ relatives ____ friends ____ neighbors ____ Meals on Wheels ____ church/synagogue

What assistance do you receive from other community agencies (specify) _____

Neighbors who can check on care receiver in an emergency:

Name Address Daytime phone Evening phone

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Congregational affiliation: _____

This form was completed by: ____ self If other than self: _____
Name Phone

SEND COMPLETED ASSESSMENT TO:

Jane Hart, Exec. Dir.

Hart Felt Ministries

P. O. Box 54699

Jacksonville, FL 32245

Phone 904-538-0306

Fax 904-538-0307