

Faith in Action **New Client Application** (intake)
329 North Cameron Street #200 , Winchester, VA 22601

Personal Information - Request for Service:

Date:_____

GENERAL INFORMATION

Applicant Name: _____ Date of birth: _____

Address: _____

Email address: _____

Home Phone: _____ Cell Phone: _____

Location of / Directions to your house from Winchester City:

PROFILE

Sex: Male / Female

Ethnicity (optional): African-American Asian/Pacific Islander Latino Native American
Caucasian Other

Marital status: single married separated divorced widow/widower

Living arrangement: live alone live with spouse/family live in nursing home other

Congregation (optional): _____

Are you a Veteran? _____

Education (optional): ___ non high school graduate ___ high school graduate ___ college graduate

Pets: _____

COMMUNICATION BARRIERS

___ Hearing impaired ___ Speech impaired ___ First language other than English: _____

DO YOU CURRENTLY USE ANY OF THE FOLLOWING SERVICES?

No	Yes		No	Yes	
		Case Management			Legal
		Adult Day Care			Mental Health (Inpatient/Outpatient)
		Congregate Meals / Senior Center			Personal Care
		Visitor check-in (or phone call)			Transportation
		Home Delivered Meals			Other
		Home Repairs			

MOBILITY Circle the following equipment used to help with your mobility in or outside the home:

Manual Wheelchair Power Wheelchair Cane Walker Portable Oxygen

Service animal Other: _____

Please list mental or physical limitations (including memory loss) so that Faith in Action may be in a better position to serve your medical transport needs:

MEDICATION issues/problems

- ___ Adverse reactions / allergies
- ___ Taking medication on time and as prescribed

HEALTH HISTORY

Do you smoke ? _____

Primary Care Physician: _____ **Phone:** _____

Address: _____

Specialist: _____ Phone: _____

Address: _____

Specialist : _____ Phone: _____

Address: _____

FAMILY:

Family member or Emergency Contact person:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Work Ext: _____

Family member or Emergency Contact person:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Work Ext: _____

How often are you in touch with family or friends?

___ Daily ___ Weekly ___ Monthly ___ Less than monthly ___ Never

Are family or friends available to drive you to medical appointments ?

How have you been getting to your medical appointments ?

OTHER CONTACTS

Social Worker: _____

Home Health Agency: _____

Case Manger: _____

Informal Caregiver: _____

INCOME

After taxes, in what range is your monthly (family) income ?

___ \$457 or less ___ \$458-\$1249 ___ \$1250-\$1666 ___ \$1667 or more

INSURANCE COVERAGE (circle/list):

Medicaid / eligible

Medicare

Private: _____

Other: _____

If you have Medicaid coverage, are you eligible for Logisticare transportation ? _____

I, _____ have provided accurate information to the best of my knowledge and I have read and understand Faith in Action Client Guidelines.

Client Signature

Date

CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services for benefits. My signature below is my consent to share information for that purpose.

The following agencies are able to exchange information:

- Faith in Action
- Volunteers (Drivers)
- Physicians Office
- Family Member / Caregiver
- Department of Social Services

This information is to be exchanged only for service coordination, anonymous data reporting and determining eligibility. Information will be shared by written information, in meetings, by phone or computer.

I can withdraw this consent at any time by informing the referring agency. At that point, listed agencies will be instructed not to share information I have provided.

Signature: _____

Date _____