KAREGIVERS OF AMERICA APPLICATION (PRINT)

24 HOUR IN HOME CARE KAREGIVERS

KAREGIVER INFORMATION

FULL NAME: _____ DATE OF BIRTH: _____/_____/_____

HOME ADDRESS: _____

EMAIL ADDRESS: _____

CELL PHONE NUMBER: HOME PHONE NUMBER:

(_____) _____-_____ (_____) _____-_____

EMERGENCY CONTACT/NUMBER: _____/(_____) _____-_____

YEARS AS A KAREGIVER: _____YRS

WHO DO YOU CARE FOR? _____

DO YOU HAVE PETS, IF SO PLEASE LIST:

_____

DO YOU HAVE RELIABLE TRANSPORTATION? YES NO

DO YOU HAVE ASSISTANCE AT HOME? YES NO

WHO REFERRED YOU TO K.G.O.A.? _____

DESCRIBE YOURSELF:

_____

_____

ABOUT THE LOVED ONE

NAME:_____ BIRTHDAY: _____/_____/_____

IS HE/SHE WILLING TO LET SOMEONE ELSE KARE FOR THEM?

YES NO

HAVE YOU EVER HAD HELP FROM A HOME HEALTH CARE AGENCY?

YES NO

DOES YOUR LOVED ONE HAVE SPECIAL NEEDS, IF SO PLEASE LIST:

_____

_____

NEED ASSISTANCE WITH MEDICATIONS/FEEDING/OXYGEN/GOING UP AND DOWN STEPS? YES NO

CAN YOUR LOVED ONE (check all that apply) WALK ____ TALK ____ HEAR____ SEE____

DOES YOUR LOVED ONE HAVE ANY ALLERGIES, IF SO PLEASE LIST:

_____

DESCRIBE YOUR LOVED ONE:

_____

_____

LAST VISIT TO THE HOSPITAL? _____

IF K.G.O.A. OR BRIGHTSTAR NOTICE ANY ABUSE WE RESERVE THE RIGHT TO NOTIFY THE APPROPRIATE PEOPLE AND WILL MAKE YOU AND THEM AWARE

FOR OFFICE USE ONLY:

INTERVIEWED BY: _____ DATE: ____/____/____

HOME HEALTH CARE NOTIFIED SPOKE WITH: _____

DATE:___/____/____

HOME HEALTH CARE INTERVIEW DATE SET FOR: ____/____/_____

HOME HEALTH CARE AGENCY WILL CONTACT KAREGIVER:_____