**APPLICATION FOR SERVICES: 2025**

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| Name:  | Date: |
| Street: | Phone #: |
| City, State: | Zip: | Birth date:  | Age:  |
| E-Mail: |  Marital StatusReligious Denomination: |
| Do you live alone? Yes [ ]  No [x]  Gender: M F Ethnicity: Primary Language:  |
| Monthly Income | SSI Income: | Total Monthly Income: (include pensions) |
| Use this info for 2024 to evaluate poverty level:  1 individual= $20,345/yr. 1,695.42mo.  | Any other source to meet nutritional needs? (specify) | If meets income criteria and no other nutritional food source, apply for meal services and mail to Dana Davidson at ddavidson@bgadd.org & refer to Stacy Federico at mom1991.sf@gmail.com  |
| **Emergency Contact, Referral Source, & Medicaid Status** |
| Name: | Anyone with a key to your home or apartment911 call ok?  |
| Address: | Insurance with who? Preferred Hospital?  |
| Primary Phone:  | Secondary Phone: | Medicaid waiver application $2465/mo | BADDAD Ref? Dana Davidson859-810-2501 |
| Relationship: | Who referred this person to our program?  |

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| --- |
| **Other** |
| Do you currently have any pets? Would you be open to a certified pet therapy dog, visiting you? Yes [ ]  No [ ]  Yes [ ]  No [ ]  |
| Grocery shopping: (who does the grocery shopping) |
| Transportation: (cite usual mode of transportation) |
| Meal Preparation: (who prepares the meals)COVID Vaccination Status\_\_\_\_\_\_\_\_\_\_\_ Flu Shot (date)\_\_\_\_\_\_\_\_\_ |
| **Impairments which impact Activities of Daily Living (ADL)** |
| **□** Hearing\_\_\_\_**□** Vision\_\_\_\_ **□** Speech\_\_\_\_ **□** Walker\_\_\_\_ **□** Wheelchair\_\_\_\_ □ Uses oxygen\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Preferred Schedule for calls-UNIPER** |
| Days: □ **M** □ **T** □ **W** □ **Th** □ **F** □ **Sa**  | Interested in UNIPER? Y or N (circle) If yes, refer to 323 703 5053 Mandi |

 **Social Connections**

Social Connections per week (pick a number 1-no social connections to 10 social connections)

**1 2 3 4 5 6 7 8 9 10**

**How satisfied are you with your social connections**

 **Not satisfied 1 2 3 4 5 6 7 8 9 10 extremely satisfied**

 **Release of Information**

In an effort to meet the needs of Participants, it is sometimes necessary to contact and share information with other community services and agencies. This may include the disclosure of personal or confidential information. Sharing this information is intended to assist Participants of the Program.

 \_\_\_\_\_\_\_\_\_\_ I authorize **(your name here)** A Caring Place to obtain and/or disclose confidential information to/from other community social service agencies.

\_\_\_\_\_\_\_\_\_ I authorize my photograph to be published for marketing purposes, or to enhance our newsletter of social media site.

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

 Participant Signature Date

 **Welfare and Safety Check**

In the event that we are not able to reach you or your listed emergency contact by telephone after 48 hours, we may then contact local law enforcement and ask them to initiate a welfare and safety check. This means that the police will arrive at your home to make certain that you have not had an emergency.

Some participants do not wish us to notify the police under any circumstances. Please check below if this is your preference.

[ ]  I permit you to call 911 for a welfare and safety check if you cannot reach me by phone and cannot reach the emergency contact number I have provided.

 If you cannot reach me by phone or my contacts, and I have not called to say I would be away, please **do not** initiate a welfare and safety check.