Aging & Disability Resource Center of La Crosse **Date:____/____/_______**
Peer Caregiver Support Program – RECIPIENT Sheet

Name:_______________________________ **Middle**:___________________ **Last**____________________________

Address:____ **Phone**:_______________________

City:______________________________, **WI Zip**:__________ **Other City Lived In**:________________________

Email:__________________________________@________________________________ **DOB**:____/____/______

Do you have any medical conditions or concerns that the Volun-Peer Mentor should be aware of, or that you might need special consideration for? Yes or No

Describe:____

____

Medical Conditions: ____CHF (Congestive Heart Failure) ____ COPD (Chronic Obstructive Pulmonary Disease)

___ Macular Degeneration ____Multiple Sclerosis ___Cerebral Palsy ___Parkinson's Disease ___Epilepsy

___ Lupus ___Rheumatoid Arthritis ___ Kidney Disease ___Cancer ___ Other:__________________________

Description:____

Do you use mobility/adaptive equipment?: ___Cane ___Walker __Wheelchair (Must transfer/ toilet independently)
___ Hearing Aids ___ Oxygen ___ Other - _____________________

Other Agency or Personal Assistance:____

Do you smoke: Y or N Cigarettes___ Pipe___ Other: __________ Must abstain while Mentor is present.

Pets: Y or N Type:________________________________ Name:____________________________

Occupation (Former or Current): ____

Does anyone else live with you? Yes or **No** **Their DOB:** ____/____/____ Or Age?_______

First Name: ____________________________ Middle Initial _______ Last Name: _______________________________

Does anyone else live with you? Yes or **No** **Their DOB:** ____/____/____ Or Age?_______

First Name: ____________________________ Middle Initial _______ Last Name: _______________________________

Does anyone else live with you? Yes or **No** **Their DOB:** ____/____/____ Or Age?_______

First Name: ____________________________ Middle Initial _______ Last Name: _______________________________

Causeway Caregivers performs a background check under the direction of The Aging and Disability Resource Center of La Crosse County on all mentors, caregivers and care recipients to determine eligibility.

Thank you for your participation in The Peer Caregiver Support Program!

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FOR OFFICE USE ONLY:

___ INTO/UPDATED DATABASE ___BACKGROUND CHECK / RESULTS:________ ___MATCHED ___ FOLLOW-UP CALL