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

**Name**:_____ **Middle**:_____ **Last**_____

**Address**:_____ **Cell or Phone**:_____

**City**:_____, **WI Zip**:_____ **Other City Lived In**:_____

**Email**:_____@_____ **DOB**:____/____/_____

**I'm a caregiver for::** ___ **Spouse** ___ **Father** ___**Mother** ___ **Brother** ___**Sister** ___ **Grandparent**_____
___ **Son** ___ **Daughter** ___ **Friend** ___**Neighbor** ___ **Other** _____

**Have you been in contact with the Aging & Disability Resource Center of La Crosse County (ADRC)? Yes** or **No**

**Would you like to receive more information from the Aging & Disability Resource Center? Yes** or **No**

**Other Agencies providing assistance:** _____

**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:**_____

_____

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

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

**Do you have pets: Y** or **N** Type:_____ Name:_____

**Occupation** (Former or Current): _____

**Can You Get Into:** ___Car ___Truck ___SUV __Van **Do You Use?:** City Bus / County Bus / Transport Service

**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.**

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**Volun-Peer Mentor Matching:** Provide any information about yourself that will help in finding a lasting mentor match.

**Hobbies:** _____

**Favorite Books, Movies, TV Programs:**:_____

**What do you enjoy talking about:** _____

**Where have you (or would you) like to travel:** _____

**Share additional interests here:**_____

**If someone other than the caregiver completed this form with their permission, please provide your:**

**Name:** _____ **Relation to Caregiver** _____

**How did you hear about this program?** _____

**Mentors Will:**

- Have previous caregiving experience
- Be a good listener with empathy and understanding
- Be accepting and respectful of caregivers emotions and differences
- Provide moral support
- Share their caregiving experience, strength and hope
- Make first contact and maintain contact with the caregiver at the time, frequency agreed upon
- Understand the limitations and demands of the caregiver and respect their privacy and personal space

**Mentor Will Not:**

- Provide the caregiver or recipient advice on:
    1. Medical decisions
    2. Family or Personal matters
    3. Financial decisions
    4. Administer medications
    5. Provide personal care
    6. Provide transportation

**VOLUN-PEER MENTOR SERVICES:** Provide support and encouragement to caregiver(s) of a recipient

Please check all that are of interest

(Time given denotes acceptable length of service)

___ **Phone, Email, Visiting** Call, email or visit at least once a week to encourage and support (2-4 hrs/month)

___ **Socialization** Spend time with caregiver and recipient for socialization in the community (2-4 hrs/month)

___ Arts Buddy with Causeway Caregivers: Attend live performances at local venues

___ **Attend Lunch Bunch or Support Groups** Provide transportation for caregiver and recipient (2-4 hrs/month)

___ **Office Volunteer** Assist in the office with mailings or newsletter, compiling mentor hours, etc (2 hrs/month)

____ **Other** :_____ (Varies)

**Best time to Call**: _____:_____ AM or PM or _____:_____ AM or PM **Answering Machine? Yes** or **No**

**Frequency:**: ____ Daily _____Weekly _____Bi-Weekly _____1x Month _____ As Needed (with 24 hour notice)

**Best Time:** _____ Morning _____Afternoon _____Evening _____During the week _____Weekends

**Do you leave for winter? Y** or **N** Dates Gone: _____ - _____

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

FOR OFFICE USE ONLY:

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