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

First:__________________________ **Mliddle**:________________________ **Last**:__________________________

Address:____ **Phone**:_________________________

City:_____________________________ **State**:____ **Zip**:____________ **Cell:** __________________________

Email:________________________________@_______________________________ **DOB:** ____/____/_______

Occupation (Former/Current):______________________________ **Employer:**_____________________________

Work Number:___________________ **Ext #:** __________ **Hours:**_________ **Okay to Call You There?: Y** or **N**

VOLUN-PEER MENTOR MATCHING: Provide any information about yourself that will help in finding a lasting match.

Frequency:: _____Weekly _____Bi-Weekly ______1x Month _____ As Needed

Availability: _____ Morning _____Afternoon _____Evening _____During the week _____Weekends

Leave for Winter? Y or **N** Dates Gone: ________ - _________

What service area?: __All ___ Northside __ Southside __ Onalaska __ Holmen __ West Salem __ Bangor

How did you hear about this program?:____

Health Issues:_____________________________________ **Restrictions?: Y** or **N** ________________________

Do you smoke: Y or N ___ Cigarettes ___ Pipe ___ Other______________ ***Must abstain while volunteering.***

Any allergies to: ___ Dogs ___ Cats ___Birds ________________ Other **Prefer NO Pets:** _____

Previous mentor experience: ____

Previous caregiving experience: ____

Hobbies: ____

Favorite Books, Movies, TV Programs::____

What do you enjoy talking about: ____

Where have you (or would you) like to travel: ____

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)

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As a volunteer within The Aging and Disability Resource Center of La Crosse County for the Peer Caregiver Support Program. you share your time and talents by being matched with a person who has requested a Volun-Peer Mentor. In order to ensure volunteer safety and the quality of our program work, we ask you to please read and respond to the following questions.

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.

Full Legal Name:____ Middle Name: ______________________

Former / Maiden Name(s): ______________________________________ Date of Birth: ____/_____/______

Have You Lived Outside of WI in the past three years? Y or N If Yes, list locations and dates of residency

City:______________________________ State: ________ Date: _________________ to ______________

City:______________________________ State: ________ Date: _________________ to ______________

City:______________________________ State: ________ Date: _________________ to ______________

Have you completed Volun-Peer Orientation? ___________________ Date: ______/_________/__________

Have you voiced your questions? ____

Do you understand there is a risk involved when volunteering? _______________________________________

Do you understand you must volunteer within the guidelines/instruction of The Aging and Disability Resource Center of La Crosse County for the Peer Caregiver Support Program? _________________________________

If you do not volunteer within the guidelines/instruction of The Aging and Disability Resource Center of La Crosse County for the Peer Caregiver Support Program. you do you assume your own risk?_______________
Note: Failure to volunteer within guidelines may make you ineligible to volunteer

Volunteer Signature:_____________________________________ Date: ______________________

Volunteer Printed Name: _____________________________________

We thank you for your participation in The Peer Caregiver Support Program!

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FOR OFFICE USE ONLY!

___Matched ___Orientation /Date:___/___/_____ ___Into/Update Database ___Background Check/ Results:_________________