



Northwoods  
Interfaith  
Caregivers are  
Essential

# Carereceiver Application

Northwoods Interfaith Volunteer Caregivers Program

616 America Ave Suite 170 Bemidji, MN 56601

[www.northwoodsnice.org](http://www.northwoodsnice.org)

Cindi Lee Jernigan, Executive Director  
Coordinator  
(218) 333-8264 or toll free (888) 534-4432  
Fax: (218) 333-8263

Missy Thomas, Volunteer  
  
(218) 333-8266  
Email: [nice@paulbunyan.net](mailto:nice@paulbunyan.net)

**In order for us to begin serving you, please complete ALL 3 PAGES:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_ Age: \_\_\_\_\_

**I am seeking services in the following areas (check all that apply):**

**Caregiver Support Services**

- Respite Care
- Caregiver Coaching
- Homemaking
- Home Modification

**Local Transportation**

- Shopping Assistance
- Medical Appointments

Additional interests to help us make a match (hobbies/interests, enjoyable outings, etc.)

\_\_\_\_\_

Other medical information (uses walker, oxygen, insulin dependent, medical diagnosis, etc):

\_\_\_\_\_

I need assistance \_\_\_\_ hours: \_\_\_\_ a week \_\_\_\_ every two weeks \_\_\_\_ a month

**I would like a someone:**

\_\_\_\_ from my church (please list on page 3)      \_\_\_\_ from my community

\_\_\_\_ male      \_\_\_\_ female      \_\_\_\_ doesn't matter

**Emergency Contacts:**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Physician Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Health Status**

Are you on Medical Assistance (NOT Medicare):  Yes  No

**Mobility**

gets out independently  
 needs assistance  
 homebound

**Personal Care**

independent  
 needs assistance  
 total assistance

**Emotional Status**

good  
 moderate  
 other

**Vision**

good  
 moderate  
 impaired

**Hearing**

good  
 moderate  
 impaired

**Speech**

good  
 moderate  
 impaired

**Social**

many  
 some  
 few

**Living Situation**

alone  with spouse  with family  with friend  other

**Referral Source:**

friends  radio/TV  presentation  medical  self  
 church  school  newspaper  family  other

Name of Referring Partner: \_\_\_\_\_

**Please check other services you are currently using:**

Transportation services  Meals on Wheels  Senior Center  
 North Country Home Care & Hospice  Beltrami Nursing Services  Adult Day Services

**Optional Information: (answers shared may be helpful when matching volunteer with carereceiver, and will also benefit as statistical information)**

**Race:**

White  Hispanic  African American  Native American  Other

**Religion:**

Catholic  Presbyterian  Baptist  
 Seventh Day Adventist  Jehovah Witness  Baha'i  
 Evangelical  Methodist  Unitarian  
 Episcopal  Lutheran  Other

Name of Congregation: \_\_\_\_\_

Effective September 1<sup>st</sup>, 2007 Northwoods Interfaith has implemented a “Fee for Service” for all Transportation Services (such as transportation to medical appointments, grocery shopping assistance and meal deliveries). Fees are determined by a Sliding Fee Scale as well as the number of miles driven each month. Please fill out the following information to determine your “fee”.

**Please check ONLY ONE LINE that best reflects your household’s gross MONTHLY income. Please include yourself in the Family Size:**

<u>Family Size: 1</u>	<u>Family Size: 2</u>	<u>Family Size: 3</u>
___ \$0-\$1,000	___ \$0-\$1,250	___ \$0-\$1,550
___ \$1001-\$1,400	___ \$1,251-\$1,650	___ \$1,501-\$2,000
___ \$1,401-\$1,800	___ \$1,651-\$2,400	___ \$2,001-\$2,700
___ Greater than \$1,800	___ Greater than \$2,400	___ Greater than \$2,700
<u>Family Size: 4</u>	<u>Family Size: 5</u>	<u>Family Size :6</u>
___ \$0-\$1,800	___ \$0-\$2,100	___ \$0-\$2,300
___ \$1801-\$2,400	___ \$2101-\$2,600	___ \$2,301-\$2,800
___ \$2,401-\$3,000	___ \$2,601-\$3,300	___ \$2,801-\$3,500
___ Greater than \$3,000	___ Greater than \$3,300	___ Greater then \$3,500

If someone **OTHER** than the Carereceiver should receive Monthly Transportation Invoices and other “NICE” mailings,, please list here. (Include person’s name, address and relation to the Carereceiver):

---

**PLEASE COMPLETE THE FOLLOWING QUESTIONS ONLY IF YOU ARE INTERESTED IN RESPITE CARE:**

Primary Caregiver Name: \_\_\_\_\_

Primary Caregiver Age: \_\_\_\_\_

How long has the primary caregiver been caregiving? \_\_\_\_\_

Gender of Primary Caregiver: \_\_\_\_\_ Male \_\_\_\_\_ Female

Is the Primary Caregiver raising grandchildren? \_\_\_\_\_

Is the Primary Caregiver living with the carereceiver? \_\_\_\_\_

Please remember a Caregiver Support Group is available through Adult Day Services of Bemidji. For more information please call (218) 751-1324.

**Any additional comments?**

---