



**AMERICORPS SENIOR COMPANION
POTENTIAL CLIENT PRESCREEN**

Client Name: _____

Address: _____

City/State: _____ Zip: _____ County: _____

Cell: _____ Home Phone: _____

Email: _____

DOB: _____ Gender: _____ Race: _____

Marital Status: _____ Spouse Name: _____

Rent: ___ Own: ___ Subsidized Housing: ___

Do you live in a Residential or Assistant Living Facility: _____

Primary Language: _____ Do you speak English: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Emergency Contact Address: _____

Emergency Contact Email: _____

Relationship to Emergency Contact: _____

List all persons living in the home with you: Name/Age/Relation

1. _____
2. _____
3. _____
4. _____

Does someone have a Power of Attorney concerning you? List who and provide copy.

Are you or your spouse a Veteran: _____

Medical Questionnaire

Are you disabled: _____

Circle all that applies

Physical Problem Asthma (or other breathing problems), Blindness (& partial blindness), Deafness (& partial deafness). Diabetes, Dizziness/Balance problems, Epilepsy, General Hearing Difficulty, Mobility Problems, Neurological Problems, Paralysis, Physical Weakness, Speech Problems, Seizures, Age-Related Cognitive Decline, Any Psychiatric Condition (see exclusions below), Autism, Depression, Dyslexia, Bipolar Disorder, Emotionally Overwhelmed, Panic Attacks, Post Traumatic Stress Disorder (PTSD), Separation Anxiety, Social Phobia, Stress Problems

Other

Are you seeing your doctor on a regular basis: _____

Social

Are you getting to the Grocery Store/Errands regularly: _____

Do you have another Care Provider that helps you: _____

Are you often alone and feel unsafe: _____

Are you in need of additional food, medical help, help with house/household repairs and chores _____

Print Name: _____

Signature: _____ **Date:** _____