

AMERICORPS SENIOR COMPANION OF HARRIS COUNTY, TX**POTENTIAL CLIENT PRESCREEN**

Date: _____

Client Name: _____

Address: _____

City: _____ Zip: _____ Harris County Resident: _____

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: _____

Are you a Veteran: _____ Spouse of Veteran/Active Duty: _____

EMERGENCY INFORMATION

Emergency Contact Name: _____

Emergency Contact Number: _____

Emergency Contact Address: _____

Emergency Contact Email: _____

Relationship to Emergency Contact: _____

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

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

Does someone have a Power of Attorney concerning you? _____

If so, name: _____

MEDICAL QUESTIONNAIRE

Circle all that apply

Are you disabled: _____ Having physical or mental impairment that substantially limits one or more major life activities.

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, Prone to falling,

Other _____

Do you see your doctor/dentist regularly: _____ Dentist: _____ Other: _____

SOCIAL

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

Do you have Care Provider: _____ Name: _____

Are you often alone: _____

Are you in need of additional food, medical help, or assistance with household repairs or chores? _____ If so, in what area: _____

REFERRAL Agency: _____ Community Event: _____ Ad/Social Media: _____

Please be advised that completing and signing this form does not imply that you have been enrolled in the AmeriCorps Seniors Senior Companion Program. This document is for screening purposes only. It helps us determine if we can meet your needs and identify a suitable Volunteer Companion.

Referral by: _____ Phone/Email: _____

Signature of Potential Client: _____ Date: _____

Signature of Family Member: _____ Date: _____

If applicable

OFFICE USE ONLY:

Date Received: _____ Call/Emailed: _____ Staff Initial: _____