



Care Receiver Application

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(218) 333-8264

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(218) 333-8098

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Coordinator (218) 333-8266

Jenn Cole, Dementia Program Manager

(218) 333-8097

Kim Jansson, Caregiver Advocate,

(218) 333-8265

Perri Adelman, Respite &

Transportation Coordinator

(218) 333-8262

Serenity Walker, HCBS

Program Manager

(218) 333-8262

Denise Smid, Homecare Manager

(218) 333-8204

In order for us to begin serving you, please complete ALL 4 PAGES and SIGN the application on the bottom of the last page:

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____ Gender: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Legal Status: ___ Responsible for Self ___ Under Guardianship/Conservatorship

 ___ Under Commitment ___ Power of Attorney

***If someone OTHER than the Care Receiver should receive Monthly Transportation Invoices and other mailing from Northwoods Caregivers, please list here.**

Name: _____ Relation to Care Receiver: _____

Address or Email: _____

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

Caregiver Support Services

- ___ Respite Care
- ___ Caregiver Coaching
- ___ Homemaking

Local Transportation

- ___ Shopping Assistance
- ___ Medical Appointments
- (NOT available if on MA)

____ Home Health Care

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

I need assistance ____ hours: ____ a week ____ every two weeks ____ a month

I would like someone:

____ from my church (please list on page 3) ____ from my community

____ male ____ female ____ doesn't matter

Health Status

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

Are you on Medicare? ____ Yes ____ No

Have you ever served in the military? ____ Yes ____ No

If yes, are you a service connected Disabled Veteran? ____ 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

Current Medical History (walker, oxygen, insulin dependent, medical diagnosis, Alzheimer's, etc.): _____

Special Dietary

needs: _____

Allergies: _____

Living Situation

____ alone ____ with spouse ____ with family ____ with friend ____ other

Emergency Contact:

Name: _____ Phone: (____) _____

Primary Physician Name: _____ **Phone:** (____) _____

Please check other services you are currently using:

_____ Transportation services _____ Meals on Wheels _____ Senior Center
_____ Sanford HomeCare _____ County Health _____ Adult Day
& Hospice & Human Services Services

Northwoods Caregivers has a “Fee for Service” for all Respite and 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” or if left blank no sliding fee will be used and you will be billed as private pay. **Based on the sliding fee and the number of hours per week requested, we may ask for a one month deposit before starting services.**

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-\$980	_____ \$0-\$1,327	_____ \$0-\$1,865
_____ \$981-\$1,471	_____ \$1,328-\$1,991	_____ \$1,866-\$2,796
_____ \$1,472-\$1,971	_____ \$1,992-\$2,655	_____ \$2,798-\$3,729
_____ \$1,962-\$2,452	_____ \$2,656-\$3,318	_____ \$3,730-\$4,660
_____ Greater than \$2,453	_____ Greater than \$3,319	_____ Greater than \$4,661
<u>Family Size: 4</u>	<u>Family Size: 5</u>	<u>Family Size: 6</u>
_____ \$0-\$2,245	_____ \$0-\$2,720	_____ \$0-\$3,306
_____ \$2,246-\$3,650	_____ \$2,721-\$4,076	_____ \$3,307-\$4,965
_____ \$3,651-\$4,414	_____ \$4,077-\$45,382	_____ \$4,967-\$6,554
_____ \$4,415-\$5,609	_____ \$5,383-\$6,795	_____ \$6,555-\$8,277
_____ Greater than \$5,610	_____ Greater than \$6,796	_____ Greater than \$8,278

*****PLEASE COMPLETE THE FOLLOWING QUESTIONS ONLY
IF YOU ARE APPLYING FOR RESPIRE CARE or CAREGIVER COACHING:**

Primary Caregiver Name: _____

Address: _____ **City:** _____ **Zip:** _____

Primary Caregiver DOB: _____ **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 Care Receiver? _____

Please remember a Caregiver Support Group is available through our agency in Bemidji, Blackduck, and Bagley. For more information call Jenn (218) 333-8097

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

Referral Source:

___ friends ___ Radio/TV ___ presentation ___ medical ___ self
___ church ___ school ___ newspaper ___ family ___ list other

Race:

___ White ___ Hispanic ___ African American ___ Native American ___ Other

If Native American, what is your Tribe Affiliation: _____

Ethnicity: _____ Hispanic _____ Non-Hispanic

Religion: **Name of Congregation:** _____

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

Any additional comments?

*Once we receive and process this application, please look for a **Welcome Packet** in the mail. In this packet will be your Care Receiver Manual, sliding fee determination, if applicable, brochures, among a few other important pieces of paperwork. This packet will give you all the information you need in order to proceed in receiving services.

**Thank you for choosing Northwoods Caregivers
and we look forward to serving you!**

Signature of client/guardian: _____

(Required in order to provide services)

Date: _____