



Carereceiver Application

616 America Ave Suite 170 Bemidji, MN 56601

www.northwoodscaregivers.org

Email: nice@paulbunyan.net

Fax: (218) 333-8263

Cindi Lee Jernigan, Executive Director Advocate

(218) 333-8264 or toll free (888) 534-4432

Jenn Cole, Dementia Program Manager

(218) 333-8097

Perri Adelman, Program Assistant

(218) 333-8262

Denise Smid, Homecare Manager

(218) 333-8204

Karen Bedeau, Dementia Outreach
(218) 333-8098

Jennie Hughes, Billing & Media Coordinator

(218) 333-8266

Serenity Walker, HCBS Program Manager

(218) 333-8262

Kim Jansson, Caregiver Advocate,
(218) 333-8265

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 Carereceiver should receive Monthly Transportation Invoices and other mailing from Northwoods Caregivers, please list here.**

Name: _____ Relation to Carereceiver: _____

Address or Email: _____

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

Caregiver Support Services

- ____ Respite Care
- ____ Caregiver Coaching
- ____ Homemaking
- ____ Aging Life Care Management
- ____ Home Health Care

Local Transportation

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

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

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 Carereceiver, 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:** _____

<input type="checkbox"/> Catholic	<input type="checkbox"/> Presbyterian	<input type="checkbox"/> Baptist
<input type="checkbox"/> Seventh Day Adventist	<input type="checkbox"/> Jehovah Witness	<input type="checkbox"/> Baha'i
<input type="checkbox"/> Evangelical	<input type="checkbox"/> Methodist	<input type="checkbox"/> Unitarian
<input type="checkbox"/> Episcopal	<input type="checkbox"/> Lutheran	<input type="checkbox"/> 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 Carereceiver 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: _____

Revised 11/2018