

FAITH IN ACTION IN DODGE COUNTY

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FAITH
IN ACTION

CARE RECIPIENT APPLICATION

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Names and Ages of others living in household: _____

Annual Income of Care Recipient: _____

Do you receive medical assistance? _____ Medicaid _____ Medicare _____

Elderly Waiver/Alternative Care: _____ Other Waiver Program: _____

Do you have a disability? _____ If yes, what is your disability? _____

Name, address and phone number of Primary Caregiver, if applicable: _____

Smoker: Yes _____ No _____

Pets: Yes _____ No _____ If yes, what type: _____

Any allergies: (perfumes, food, medicines, etc)? _____

Are you a member of a religious congregation? Yes _____ No _____

If yes, which congregation: _____

Please list two people we may contact in case of an emergency.

Name: _____ Relationship: _____

Address: _____

Day phone #: _____ Evening phone #: _____

Name: _____ Relationship: _____

Address: _____

Day phone #: _____ Evening phone #: _____

Please check all the areas you would like assistance in:

Transportation:

___ In town

___ Out of town

___ Shopping

___ Running Errands

Help in the home:

___ Light housekeeping

___ Laundry

___ Preparing Meals

___ Mail management

Outside chores:

___ Mowing

___ Lawn raking

___ Snow removal

Visiting:

___ Friendly Visits (in person)

___ Reassurance Calls (by phone)

___ Respite Care

Comments, additional needs: _____

Case Manager Information

Name: _____

Phone Number: _____

Email: _____

Authorization Information: _____

Care Client Signature

