Volunteers in Action Providence Community Caregivers Referral Guidelines

These guidelines are designed to help families, friends, and professionals determine if someone you are working with may be appropriate for referral to *Volunteers in Action*. Please contact us at 541-387-6404 if you have any questions.

1. Individuals appropriate for referral include:
    - People with limited financial means who are medically vulnerable
    - People who are frail or elderly
    - People with a physical, mental, or developmental disability
    - Others with long-term healthcare needs

2. Services depend on the availability of volunteers. There may be times when we are unable to fill a request.

3. One week notice is required for all local requests. We do not have volunteer caregivers in the office waiting for a call. We are not designed for emergency transportation.

4. At least two week notice is required for all transportation requests outside of Hood River or Klickitat counties. Transportation to Portland & Vancouver is limited due to the small number of volunteers who are available to drive to these more distant locations.

5. A Care Receiver Application is required for each person referred. Please complete all sections.

6. A home visit will be completed by the Program Coordinator with the newly referred care receiver. The home visit must occur before volunteers will provide services, including transportation.

7. Care Receivers or their representative must call *Volunteers in Action* at 541.387.6404 to schedule services.

8. Before calling for transportation services, please be sure that you have can't use any other resources (family, hospital courtesy vans, local bus service, etc.).

9. We do not provide personal care—bathing, toileting, changing surgical dressings, etc.

10. Volunteer caregivers may not dispense medications.

11. *Volunteers in Action* serves residents of Hood River and Klickitat counties. The Program Coordinator may make exceptions, pending volunteer availability.

12. Please inform our office when a care receiver no longer needs help due to recovery, placement in a care facility, death, or some other reason.

13. There is never a charge for services provided by *Volunteers in Action.*

Care Receiver Application

Volunteers in Action

Office located in Providence Hood River at 13th & May Streets

Mail: P.O. Box 149
Hood River, Oregon 97031
Fax: 541.387.6462
Email: anna.williams3@providence.org

Date _____

General Information

Name _____ Home Phone_____
(Mr., Mrs., Miss, Ms., Dr.) Last First

Address _____ Cell Phone_____

City_____ State_____ Zip Code_____ email_____

Best way to contact you: __home phone __cell phone __text __email __other:_____

Profile

Are you connected to a community of faith? (optional) ___Yes ___No

Name of Faith Community_____

Date of Birth_____ Age _____ Gender ___ Ethnicity (optional) _____

Referral

Form Completed by:_____ Phone _____

Source of referral _____ self ____Other: _____
Name Phone

Services Requested (check all that apply):

____ Transportation
____ Having someone shop with or for you
____ Respite care (relieving family member for 3-4 hours weekly)
____ Occasional meal preparation
____ Someone to read to you
____ Someone to spend time w/ your children
____ Minor home repairs
____ Bills/record keeping/letter writing
____ Yard work/gardening
____ Caring companionship
____ Telephone reassurance
____ Other: _____

Smoker: ____ yes ____ no Pets:_____

Preferred Language: _____

Do you prefer your volunteer to be: ___female ___male ___ no preference

Are you a veteran? _____ yes _____ no

Who currently supports or assists you in your daily life? ____ relatives ____ friends

____ neighbors ____ Meals on Wheels ____church/synagogue ____Other:_____

Community agencies (specify) _____

_____

What types of assistance/support do the above provide?

_____

Needs Assessment

Living Arrangements: ____ live alone ____ live with spouse/family ____ in care facility

Other _____

Mobility: ____ cane ____ walker ____ wheelchair ____ bed bound ___ no mobility aids currently in use

Aids: (Glasses, dentures, hearing aids, etc.) _____

Sensory problems: (vision, hearing, swallowing, chewing) _____

Any health concerns you want us to know about (physical, mental, spiritual, financial, or social), including allergies and dietary restrictions:

_____

Services are not based on household income. However, we track services to low-income households for funding purposes.

Is your household at or below 200% of the Federal Poverty Guideline? (See chart below).
____yes ____no

Persons in household	200% Poverty Guideline
1	$23,540
2	$31,860
3	$40,180
4	$48,500
5	$56,820
6	$65,140
7	$73,460
8	$81,780

Emergency Information

Emergency Contact _____
Name Relationship

_____/_____
Address Phone: Day Evening

Neighbors who can check on you in an emergency:

_____
Name Address Daytime phone Evening phone

_____
Name Address Daytime phone Evening phone