

Intake Date _____

Office use: AR _____ by _____

Client Notification Date _____



Client Intake Form & Liability Release

Last Name		First Name		M	F
				<input type="radio"/>	<input type="radio"/>
Address		Apt / Unit		Date of Birth	
City		State		Zip	
Telephone		Church Congregation			
General Health		Referred By			
Email Address					
Living Arrangement		Functional Status		Services Requested	
<input type="radio"/> I live alone <input type="radio"/> I live with _____ <input type="radio"/> Independent retirement community <input type="radio"/> Assisted living		<input type="radio"/> I am able to move independently <input type="radio"/> I use a cane <input type="radio"/> I use a walker <input type="radio"/> I use a transport chair		<input type="radio"/> I need transportation <input type="radio"/> I would like visitation <input type="radio"/> I would like telephone reassurance <input type="radio"/> I would like library delivery	
<input type="radio"/> I am a veteran		<input type="radio"/> I am on Medicaid <input type="radio"/> I am on Medicare		Ethnicity: <input type="radio"/> African-American <input type="radio"/> Asian <input type="radio"/> Caucasian <input type="radio"/> Hispanic <input type="radio"/> Middle Eastern <input type="radio"/> Other _____ <input type="radio"/> Do not wish to respond	

Please Complete Page Two

Emergency Contact: Name		
Address	Primary Phone Number <input type="radio"/> Home <input type="radio"/> Work	
City	Cell Phone	
State	Zip	Email Address
What is their relationship to you? Check one: <input type="radio"/> Spouse <input type="radio"/> Daughter <input type="radio"/> Son <input type="radio"/> Other (specify)		

Client Release of Liability

In consideration for assisting me in obtaining transportation to and from my appointments, I hereby waive and release Interfaith Community Partners' officers, director, board members, employees, and volunteers from any and all liability with respect to said transportation and the arrangement for said transportation and agree to hold harmless each of them for claims arising from these services. **NOTE: *Interfaith Community Partners volunteers are unable to provide any physical assistance to our Clients.***

Client Signature **X** _____

Print Name _____

Date _____

Mail completed form to:
Interfaith Community Partners
P.O. Box 310
La Grange, IL 60525
708-354-9328
coordinatoricp@gmail.com
InterfaithCommunityPartners.org