SCP New Client Referral Survey

Introduction

The Senior Companion Program is a volunteer program with no cost to the participant. Senior Companions are age 55+, who provide friendly visits once or twice a week to homebound or isolated seniors age 60+.

The B/S/S/T Area Agency on Aging, Inc. sponsors the Senior Companion Program funded federal grant through AmeriCorps Seniors. The Senior Companion program makes every effort to connect applicants with a Senior Companion in a timely manner, based upon availability of Senior Companion volunteers.

Please note that Senior Companions DO NOT perform:

- Housekeeping, laundry, or other major household chores
- Home health aide duties, such as administering medications
- Personal care assistance, such as bathing, feeding, and dressing
- Pay bills, manage finances nor budgeting matters

For assistance with any of these above-mentioned activities, please contact the B/S/S/T Area Agency on Aging, Inc. to speak with one of our Care Managers at 1-800-982-4346.

Please complete the following survey to submit a new client referral:

Today's Date ________________________

What is the Source of the referral?

Active Living Centers/Seniors Organizations

B/S/S/T Area Agency on Aging Internal Referral

B/S/S/T County Human Services Organizations

Family Member, Caregiver or Relative of applicant

Hospice Provider

Home Health Organization

Self- Referral (I would like a Senior Companion)

Senior Living Facility Coordinator

Veterans Organizations

Other: ____________________________________

What is your relationship to the referred participant? ________________________________

I attest that the person for whom I am making this referral has been told about the program and has expressed interest to participate.

Yes No

Participant's LAST NAME: ______________________________________

Participant's FIRST NAME: ______________________________________

Participant's Phone Number: ___________________________________

Participant's Street Address: ____________________________________

Participant's City: ____

Participant's Zip Code: _______________________

Participant's Date of Birth: _______________________

Participant's Gender:

Male

Female

Self Describe: ________________

Participant's Race:

American Indian/Native Alaskan

Asian

Black/African American

Native Hawaiian/Other Pacific Islander

White/Caucasian

Participant's Ethnicity:

Hispanic or Non-Hispanic

Does the participant live alone?

Yes No Don't Know/Unknown

Is the participant a Veteran?

Yes No Don't Know/Unknown

Will a family caregiver also benefit from having a Senior Companion placed with this participant? (Family Caregivers are defined as family members who live in the area and provide substantial time caring for this person.)

Yes No Don't Know/Unknown

Participant's Special Needs (Check ALL that apply)

Alzheimer's disease

Chronic Care Disabilities/Frail Elderly

Developmentally Disabled

Emotionally Impaired

Hearing Impaired

Short-Term Disabilities

Substance Abuse

Terminally Ill

Visually Impaired

Other Special Needs

None of the above

Additional Information about Special Needs:

Please feel free to add clarifying information about any condition listed above. It is helpful for the Senior Companion to have as much information about health conditions as possible.

Does the participant have a mental health diagnosis?

Yes No

Has an in-home assessment been conducted for this participant?

Yes No

Is the home environment and participant living situation suitable for placement with a volunteer? Suitable placements are those in which the volunteer feels safe and comfortable. Unsuitable placements are those in which housing conditions are unsafe, unclean, or dangerous.

Yes No Don't Know/Unknown

Are there pets in the participant's home?

Yes No

Does this participant smoke?

Yes No

What is the approximate number of steps/stairs to access the participant's home? (Some Senior Companions have mobility issues, so this is helpful to know ahead of time).

Care Manager's OR Other Referring Party's FIRST NAME: ________________________________

Care Manager's OR Other Referring Party's LAST NAME: _________________________________

Care Manager's OR Other Referring Party's Phone Number: ______________________________

Care Manager's OR Other Referring Party's Email Address: _______________________________

Point of First Contact Person: (Whom should we contact first?)

Participant

Care Manager OR Referring Party

Other: ____________________________

Please check any services that the participant is currently receiving,

Providing this information helps the Senior Companion to understand what other supportive service, if any, the participant is receiving. (Check all that apply)

Home delivered meals (“Meals on Wheels”)

Housekeeping assistance

Home health aides (bathing,, dressing, etc.)

Hospice Care

Visiting nurses (help with medical needs)

None of the above

What are the participant’s needs that warrant this Senior Companion assignment (i.e. why is a Senior Companion needed or desired)?

Please list any hobbies, interests and/or activities the participant may enjoy.

What is anticipated impact of this Senior Companion assignment? (Check all that apply)

Increased Socialization

Increased functioning

Decreased loneliness

Accompaniment to appointments and other community activities

Caregiver respite

Other: ____

Please return completed form to Senior Companion Program Director June Werner at
jwerner@bsstaaa.org
Or mail to:
B/S/S/T Area Agency on Aging, Inc.
220 Main Street, Unit 2
Towanda, PA 18848