Anoka County Community Action Program, Inc. **1201 89th, Ave. NE, Suite 345, Blaine, MN 55434**

SENIOR KINSHIP REFERRAL

For Anoka County residents only and please note: this program does **NOT** serve those on waivers or in assisted living facilities.

Today's Date: _____ Referral Source/Name: _____ Phone:_____

Email: _____ Relationship to Client: _____

Who should be contacted when a volunteer becomes available? ***(Check one)***

☐ **Referral Source** ☐ **Client** ☐ **Other**_____

Name Phone Number

If requesting client to be contacted directly, please ensure they are aware of the referral

CLIENT INFORMATION

Client Name_____ **Phone Number** _____

Client Address_____ **Apt No.**_____

City/State/Zip Code_____ **Date of Birth** _____

Emergency Contact_____**Relationship**_____**Phone**_____

CLIENT PERSONALITY PROFILE

Veteran Status ☐ YES ☐ NO

☐ Talkative ☐ Quiet/Shy
☐ Easy Going ☐ Hard to Please
☐ Other_____

Client Smokes ☐ YES ☐ NO
Hoarding ☐ YES ☐ NO
Client has Pets ☐ YES ☐ NO
What kind? _____

LIVING ARRANGEMENTS

Client Lives: ☐ Alone
☐ With family/spouse
If so, most of the day is that person:
☐ at home ☐ at work

Transportation: (check one)
☐ Client does not drive
☐ Client drives only in limited area.
If so, where?_____
☐ Client does not drive in winter
☐ Client drives with no restrictions

HEALTH CONDITIONS

Ambulatory ☐ YES ☐ NO
Uses Cane ☐ Uses Walker ☐
Wheelchair ☐ ☐ YES ☐ NO
Independent Transfer ☐ YES ☐ NO
Mental Health Barrier ☐ YES ☐ NO
Bedridden ☐ YES ☐ NO
Breathing Difficulty ☐ YES ☐ NO
Portable O2 ☐ YES ☐ NO
Short of Breath ☐ YES ☐ NO
Uses Oxygen ☐ YES ☐ NO
Diabetic ☐ YES ☐ NO
Incontinent ☐ YES ☐ NO

HEALTH CONDITIONS

Memory Loss ☐ YES ☐ NO
Hearing Loss ☐ YES ☐ NO
Vision Loss ☐ YES ☐ NO
Seizures ☐ YES ☐ NO
Allergies ☐ YES ☐ NO
Smoke ☐ Cats ☐ Dogs ☐ Other ☐
Malnourished ☐ YES ☐ NO
Socially Isolated ☐ YES ☐ NO
Other (explain) _____

SERVICES NEEDED

- ☐ **Visiting**
- ☐ **Errands/Outings**
- ☐ **Reading/Writing**
- ☐ **Play Cards/Games**
- ☐ **Other** (explain)_____

HOURS

- ☐ **Two** hours per week
- ☐ **Three** hours per week
- ☐ **Four** hours per week

☐ Every Week
or
☐ Every Other Week

Is a female companion OK? ☐ YES ☐ NO

Is a male companion OK? ☐ YES ☐ NO

What should be the Kinship Volunteer's goal while serving this client? _____

_____

_____

_____

_____

Any Additional Comments? _____

_____

_____

_____

_____

Complete and mail to:
Sarah Anderson
Senior Kinship Program
1201 89th Avenue Suite #345
Blaine MN 55434
763-783-4745

OR

Email to:
SeniorKinship@accap.org

FAX to:
Senior Kinship Program
763-783-4700

Referrals will not be taken over the phone

For ACCAP Office Use Only:

Client Declined Kinship Service ☐ Client Contacted, No Response ☐ Client Accepted ☐

If client accepted, please complete the following: ACCAP Intake ☐ Kinship Paperwork ☐ Enter in Database ☐

Notes: _____

Revised 07/2020