Increase seniors' access to healthcare, enhance independent living, and reduce isolation primarily through transportation and visitation.

Client Application

Name: ____ Date: ______/______/________

Address: ____ Apt #:______________

Town: _______________________________ Phone(s):_______________________________

Detailed Directions: ____

____

E-Mail Address: _______________________________________ Are you a Veteran: ☐ No ☐ Yes

Church Affiliation:________________________________ Date of Birth: ______/______/_____

How did you find out about Caleb Caregivers? _______________________________________

Assistance You Would Like To Receive from Caleb...

Check the item(s) below that could assist you in becoming or remaining independent:

- ❏ Visiting
- ❏ Telephone Reassurance
- ❏ Yard Work (gardening, etc…)
- ❏ Light Housekeeping
- ❏ Transportation
- ❏ Light Home Chores/Repairs
- ❏ Food Box (CSFP) Delivery
- ❏ Other (please list):

Assistance You Already Receive Elsewhere...

Check all of the following agencies/programs that are assisting you:

- ❏ Home Health
- ❏ Granite State Independent Living
- ❏ North Country Transportation
- ❏ Lifeline
- ❏ Dept. of Health and Human Service
- ❏ Other (please list)

Please complete both sides of this application

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Emergency Contacts

Name: ______________________________ Phone (H) ____/____/____ (W) ____/____/____
Address :____Relationship: ________________
E-Mail Address____

Name: ______________________________ Phone (H) ____/____/____ (W) ____/____/____
Address :____Relationship: ________________
E-Mail Address____

Name: ______________________________ Phone (H) ____/____/____ (W) ____/____/____
Address :____Relationship: ________________
E-Mail Address____

Medical History / Current Conditions You'd Like To Share...

Who is your primary physician?_____________________Specialist?________________________

Please give a brief medical history including surgeries, ongoing ailments, and risk factors:

____

____

Do you: ☐ Live alone ☐ Live with spouse/family ☐ Live with others

Are you: ☐ Able to get out independently ☐ Able to get out with assistance ☐ Homebound

Do you use: ☐ Cane ☐ Walker ☐ Oxygen ☐ Grab Bars ☐ Prosthesis ☐ Wheelchair

I hereby state that the information given by me in this application is true in all respects.

Signature:______________________________ **Date:**______/______/________