HANDS IN SERVICE
LOVE. GIVES. BACK

# Client Application for Hands in Service

**Please PRINT unless otherwise requested**

Applicant's Name:_____ E-mail_____

Male / Female (circle) Birthday (MDY):_ _/_ _/_ _ _ Phone:(_ _ _) _ _ _-_ _ _ _ Cell Phone:(_ _ _) _ _ _-_ _ _ _

Mailing Address:_____ Postal Code: _ _ _ _ _ _

Street Address (if different from above):_____

Other individuals in household (Names, Age & Relationship to you)_____

Health Card #: _____ Year arrived in Kelowna_____ Pets (list type):_____

Source(s) of Income (circle): Disability Social Assistance Other (Specify)_____

**Services Requested** ☐ Basic Cleaning ☐ Laundry ☐ Meal Preparation ☐ Food Bank Delivery

Primary Diagnosis/Reason for Assistance/Comments:

If referral, Referrer's Name & Agency (not required)_____ Phone:(_ _ _) _ _ _-_ _ _ _ Date(MDY):_ _/_ _/_ _

List all the agencies you receive help or support from: _____

_____

Are you connected with a local church? Yes / No (circle) Church name: _____
Have you contacted your church? Yes / No (circle)

Do you have family in the Okanagan that can provide assistance? Yes / No (circle)
Relationship to you_____
Have you contacted them? Yes / No (circle)

**Needs Assessment:**

**Mobility Requirements** (circle): wheelchair / walker / cane / crutches / oxygen/ other (list):_____

Do you require assistance in making decisions about our services? Yes / No (circle)

If yes, please list your support person:_____

Relationship_____ Phone:(_ _ _) _ _ _-_ _ _ _

Please circle: **Vision**: good / fair / poor **Hearing**: good / fair / poor **Memory**: good / fair / poor
**Smoker**: Yes / No **Alcohol Use**: none /occasional / regular **Communicable diseases, identify:** _____

**Other information affecting home visits**: _____

I, _____ (applicant printed name) approve the release of my personal information as shown above with the understanding that this information is required to participate in the Hands in Service program or receive Hands in Service assistance and will only be provided to Hands in Service staff, volunteers or relevant health care providers as part of the Hands in Service program to ensure appropriate service delivery.

**Applicant Signature:** _____ **Date (MDY)**: _ _/_ _/_ _

Forms may be sent to **Field Coordinators at pam@handsinservice.ca; ruth@handsinservice.ca P 250 861-5465 F 250 861-5608**