

COUPLE PARTICIPANT INTAKE FORM

Registration Completed via:

Home

Office

Over the phone

Over e-mail

Service Requested:

Housekeeping

Grocery Shopping

Friendly Visits

Transp. to medical appoint.

Food Support

Date of First Intake: _____
mm/dd/yyyy

CONFIDENTIAL

Assigned cleaning company _____

CONTACT INFORMATION	
Last Name/Family name:	First Name/Given name:
Prefers to be known as:	Title: Miss Ms. Mrs. Mr. Dr. Other
Marital Status: Married Widowed Divorced Separated Single	
Birthdate: ____ / ____ / ____ <i>Month Day Year</i>	Gender: Male Female LGBTQ2S+ Or please specify: _____
E-mail:	
SPOUSE INFORMATION	
Last Name/Family name:	First Name/Given name:
Prefers to be known as:	Title: Miss Ms. Mrs. Mr. Dr. Other
Marital Status: Married Widowed Divorced Separated Single	
Birthdate: ____ / ____ / ____ <i>Month Day Year</i>	Gender: Male Female LGBTQ2S+ Or please specify: _____

E-mail: _____			
Address: _____			
Buzzer# _____			
City: _____		Postal Code: _____	
Phone (s): Home: _____		Cell: _____	
Can message be left in any of those numbers?		Yes	No
		Notes: _____	
1- Emergency Contact Information			
Name: _____			
Relationship to the person: _____			
Phone (s): Home: _____		Cell: _____	Work: _____
E-mail: _____			
Notes: _____			
2- Emergency Contact Information			
Name: _____			
Relationship to the person: _____			
Phone (s): Home: _____		Cell: _____	Work: _____
E-mail: _____			
Notes: _____			
ADDITIONAL PERSONAL INFORMATION			
Living Situation:	Living Alone	Not Living Alone	Unknown
Are there any issues of hoarding:	Yes	No	
Please describe: _____			

Does the household contain any pets: Yes No	
If yes, type of pet:	
Type of Housing:	Detached House Townhouse Duplex Mobile Home Apartment Other
Name of other household member (s):	
Language spoken at home:	Other language(s) spoken:
Ethnicity:	
Physical Considerations:	
Uses a cane Uses a walker Uses a wheelchair Memory loss - Diagnosed with Dementia or Alzheimer Mental Health: pls, describe Other please specify	Deaf/hard of hearing Blind/visually impaired Lifeline device
Do you consider yourself a homebound person? Yes No	
If response is affirmative and there are any reasons why, please describe:	
Are you accessing any other Fraser Health Authority's support services? Yes No	
If yes, please describe what type of services you are accessing.	
Source of Referral	
Self-referral Friend/Family Doctor/Nurse Referral Notes:	CHW/Nurse (HA) Pls. write name: _____ Host Org/Agency Newspaper Other please specify _____

Income Verification and Fee Category (Amount reported on line 15000 from participant's CRA 2023 Notice of Assessment)

Annual Household Income Verbally Provided: Yes No \$ _____

Assessed Fee Category:

Actual Fee Category:

Fee Category Exception:

Single income	Couple/Household Income	Category
\$22,250 or below	\$34,250 or below	A
\$22,251 - \$30,066	\$34,251 - \$55,132	B1
\$30,067 - \$37,883	\$55,133 - \$76,016	B2
\$37,884 - \$45,699	\$76,017 - \$96,899	C
Over \$45,700	Over \$96,900	D

Payment Information

How would you like to receive your invoice?

Via E-mail. _____

This e-mail address belongs to: Me Or Other. Please specify _____

Via Canada Post

What is your preferred method of payment?

Credit Card (OVER THE PHONE)

Credit Card automatic withdraws. Please call us to provide the following information:

Name on the credit card: _____

Credit Card no. _____

Expiry date _____

3-digit security no. at the back: _____

Cheque

Debit/Cash (IN OFFICE ONLY)

E-Transfer (sharereceivables@sharesociety.ca)

Notes for staff / housekeepers/volunteers or any additional information:

Consent

I consent to provide my personal information including address, phone number, living situation and, where applicable, your credit card information to SHARE Family and Community Services.

IMPORTANT (Please explain to the senior):

1. This information will be entered in an electronic database used by SHARE's Better at Home program in providing you with and/or referring you to appropriate services. Only necessary information may be shared with SHARE volunteers or contractors. Only in case of an emergency we will contact emergency responders.
2. Everyone's safety is very important to the program. SHARE treats everyone with dignity and respect regardless of race, ethnicity, language, religion, marital status, gender, age, disability, sexual orientation, political affiliation, or economic status.
3. If dissatisfied about the service they receive or if they feel their rights are not being respected, program participants have the right to complain. Making a complaint will not result in any barriers to service.
4. Program participants have the right to refuse or terminate the service if they feel unsafe.
5. SHARE program staff, volunteers and housekeepers have the right to refuse to deliver service when they feel that their workplace is unsafe.
6. A welcome and orientation package will be mailed to you. The orientation package will include policies and procedures of the Tri Cities Better at Home, your rights and responsibilities, and complaint procedure.
7. If you have any questions about the information in the welcome and orientation package, please do not hesitate to contact us.

Signature/Verbal Consent of Senior _____ Date _____

Signature/Verbal Consent of Spouse _____ Date _____

Name of SHARE Staff / Volunteer _____ Date _____