Tewksbury Congregational Church
Called to Care Intake Questionnaire

Instructions: *Please complete and return to the Pastor or to the Administrative Assistant in the Church Office.*

Person(s) Requiring Care: _____

Person Completing Intake Questionnaire: ☐ Check here for SELF ☐ Check here for OTHER

If OTHER, please complete Section A. If SELF, please skip Section A and complete Section B.

Section A: Contact Information for Person Completing Questionnaire

Name: _____		**Relationship:** _____
Home Phone: _____	**Cell Phone:** _____	**Email:** _____

Section B: Contact Information for Person(s) Requiring Care

Individual or Family Name: _____		
Street Address: _____		**Town:** _____
Home Phone: _____	**Cell Phone:** _____	**Email:** _____
Relationship to TCC: ☐ **Member** ☐ **Other** _____		
Emergency Contact Name: _____		**Emergency Phone:** _____

Brief Description of Situation: _____

_____

_____

_____

Others Providing Care (Outside of TCC) *Please check all that apply.*

☐ **Family** ☐ **Friends** ☐ **Neighbors** ☐ **Co-workers** ☐ **Other**

Description of Care that they are providing: ***(please include frequency)*** _____

_____

_____

Called to Care Intake Questionnaire

Person(s) Requiring Care: _____

Tewksbury Congregational Church is *Called to Care* for its Members and Friends. Our intent is to provide a short term cushion of support to those experiencing medical, emotional, spiritual or financial needs. To that end, we initially coordinate Care for a two month period of time and reassess at the 4 week mark. When completing the section below, please consider others (friends, neighbors, co-workers, etc…) who are also providing Care.

Request for Care from Tewksbury Congregational Church:

Yes or No		*Type of Care*	*Frequency (x per wk/mo)*	*Notes*
		Prayer		
		Pastoral Care		
		Meals		
		Errands		
		Driving		
		Babysitting		
		Pet Care		
		Companionship		
		Cleaning		
		Yard Work		
		Other		

Additional Notes: ***(If requesting meal support, please indicate allergies/preferences in the home.)*** _____

_____

_____

Please do not complete the section below this double line.

Called to Care Team Notes

TCC Care Plan ***(please include type of care and frequency):*** _____

_____

_____

_____

Preferred Mode of Communication *(with person(s) receiving care)* ☐ Phone ☐ Email ☐ Website

Care Service Dates: Start: _____ End: _____ Mid-point Review: _____

Permission to use Care Coordination Tools *(please check if "yes"):*
☐ TCC Flash and/or Care Page ☐ Facebook (Internal/Closed TCC Group) ☐ CareCalendar.com ☐ Email

TCC Care Coordinator Contact Info:

Name: _____ Phone: _____ Email: _____