Client's Name:_____

ICONNEL Catholic Foundation
Companion Job Description Intake

1120 Avenue of the Americas 4th Fl. New York, NY 10036
Tel: 1-800-915-ICON (1-800-915-4266) Fax: 1-888-301-ICON
(1-888-301-4266) http://www.ICONNEL.com info@iconnel.com

Client's Date of Birth	**Social Security Number**		**Power of Attorney (POA) Name**		
Client's Name			**POA Relationship to the Client**		
Street Address			**POA Street Address**		
City	**State**	**Zip**	**POA City**	**POA State**	**POA Zip**
Phone			**POA Phone**		
Other Names at Client's Address					
How Did you hear about ICONNEL?					
Emergency Contact Name	**Address**			**Phone**	
Alternate Emergency Contact Name	**Address**			**Phone**	
Other Name and Relationship to Client	**Address**			**Phone**	
Are There Pets in the Household? Yes____ No____	**If so what kind of pet? _____**				

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hourly Please specify desired shifts							
Live-in (5 to 7 days per week)	A Live in is available 24 hours (5 days), and works a total of 8 hours per day. **Separate Room Required for live-in Employees**					5 days/week (M-F) ____ 6 days/week (M-Sat) ____ 7 days/week____	

Requested Job Duties: (check all that apply)

1. Domestic Chores	a. ____ Laundry b. ____ Shopping c. ____ Cleaning d. ____ Ironing e. ____ Cooking f. ____ Housekeeping g. ____ For How Many Clients?
2. Companion Activities	a. ____ Keeping Company b. ____ Going for a Walk c. ____ Errands

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		d. Other: _____
3.	Diet Preferences	a. ____ Regular b. ____ Thickened Liquids c. ____ Liquid d. ____ Blended e. ____ Diabetic f. ____ Low Protein g. ____ Low Salt h. ____ Low Carbohydrates i. ____ Lactose Intolerance j. ____ Raw Foods k. ____ Macrobiotic l. ____ Vegetarian m. ____ Kosher n. ____ Allergies: (Describe) _____
4.	Sleeping Habits	a. ____ Sleeps Through the Night b. ____ Wakes Up During the Night ci. How Many Times? _____
5.	Medication Schedule	a. ____ Has a schedule b. ____ Not required
6.	Mental Status	a. ____ Alert b. ____ Depressed c. ____ Anxious d. ____ Confused e. ____ Phobias f. ____ Alzheimer's g. ____ Dementia h. ____ Coma i. ____ Violent j. Other_____
7.	Communication Problems	a. ____ None b. ____ Hearing c. ____ Speech d. ____ Vision e. Other_____
8.	Mobility	a. Weight:_____ b. ____ Self Ambulates c. ____ Walker d. ____ Cane e. ____ Wheel Chair f. ____ Bed Bound g. ____ Left Paralyzed h. ____ Right Paralyzed

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9.	Elimination Awareness	a. ____ Continent b. ___ Incontinent c. Other_____
10.	Hygiene Capabilities	a. ____ Tub Bath b. ____ Shower c. ____ Bed Bath d. ____ Sponge Bath e. Other_____
11.	Oral Hygiene	a. ____ Dentures b. ____ Upper c. ____ Lower d. ____ Brushing Teeth e. Other:_____
12.	Illnesses and Surgeries	a. ____ Parkinson b. ____ Cancer c. ____ Diabetic d. ____ Congestive Heart Failure e. ____ Kidney Failure f. ____ Emphysema g. ____ Respiratory Condition h. ____ High Blood Pressure i. ____ Arthritis j. ____ Aneurysm k. ____ Stroke l. Other:_____
13.	Injuries: (Describe)_____	a. ____ Hip Replacement b. ____ Knee Replacement c. ____ Pacemaker d. ____ Broken Bones e. ____ Amputee (describe:) _____
14.	Equipment	a. ____ Reclining Chair b. ____ Oxygen Tank c. ____ Oxygen Concentrator d. ____ Cast e. ____ Hoyer Lift f. ____ Sliding Board g. ____ Hospital Bed h. ____ Shower Chair i. ____ Feeding Tube

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	j. ____ Commode k. ____ Urinal l. ____ Catheter m. ____ Bed Pan n. ____ Diaper o. ____ Dialysis Machine p. ____ Colostomy Bag q. ____ Other: (Describe)_____

By Signing Below, the Employer Agrees to the Following:

I certify that all of the information above is correct to the best of my knowledge. As the employer, I am responsible for the employee once hired from the ICONNEL Catholic Foundation (ICF). I fully understand the policy and agree to pay the fee to ICF equal to $55/ week for an hourly caregiver who works less than 20 hours/week, $110/week for an hourly caregiver who works more than 20 hours/ week, and $110/week for a live-in caregiver as services rendered (see hiring agreement). All information provided to the Client involving job applicants is proprietary and owned by ICF and is intended only for the parties listed in this agreement. ICF is a non-profit private operating foundation and relies on your contributions to help the community. Therefore, any direct contact with any ICF registered job applicant without ICF's knowledge and consent prior to signing a service agreement may subject the CLIENT to an automatic default of services rendered. Any dissemination of this information in any form to third parties is strictly prohibited for the protection of the candidates. In the event that a registered ICF job applicant is hired by a third party as a result of information attained through ICF, the Client agrees to pay the standard ICF fee. I understand that not all candidates being considered are certified home health aides or are not or licensed or certified by the NY Department of Health and the Connecticut Department of Health as home health aides and homemaker home health aides, respectively. ICF is qualified under IRS regulations as a 501(c)3 charity, and your fee contributions are fully tax deductible to the extent allowed by law. Thank you.

_____ _____

Employer or Employer's Power of Attorney Signature Date

_____

Print Name