BENJAMIN ROSE INSTITUTE ON AGING
SERVICE • RESEARCH • ADVOCACY

Senior Companion Program
Benjamin Rose Institute on Aging
11890 Fairhill Road
Cleveland, Ohio 44120
216.791.8000

Please Fax to:
SCP Staff @
216.373.1814

Request for Senior Companion Services

Date_____

SCP Station _____ Contact Person _____ Phone _____Ext. _____

Client Name: _____ Address_____

Telephone: _____ Directions to home: _____

Legal Representative: Yes/ No If yes, please list, POA / Guardian/Emergency Contact _____

On Bus Route: Yes/No Driver Needed: Yes/No Primary Language: _____ Secondary Language: _____

DOB: _____ Age: _____ Gender: (Please circle one) Female Male	Race/Ethnicity: * (optional) (Please circle one) White Black Asian Hispanic Native American Other (Specify)	Living Arrangements: (Please circle one) Alone Spouse/Partner Adult Child Other Relative Non Relative	Marital Status: (Please circle one) Single Widowed Married Divorced Unknown	Housing Type: (Please circle one) House Apartment Group Home Assisted Living Veteran: (Please circle one) Yes No

Does the client smoke? Yes/No Does the client have pets? Yes/No, if yes please list. _____

Service Request: (Please circle one)	Service Frequency: (Please circle)
Needs Socialization	Days requesting: M, T, W, TH, F
Respite	No preference, needs _____times/wk (1x, 2x, 3x, 4x)
Assistance with Daily Living	Hours/week _____ Prefers: a.m. or p.m.
Companionship	Special need(s), please list_____

Does the client have any known medical diagnoses or symptoms in the following areas? (If so, please list)

1) Mobility impairment	Yes/No _____	7) Drug/Alcohol dependency	Yes/No _____
2) Memory impairment	Yes/No _____	8) Terminal illness	Yes/No _____
3) Visual impairment	Yes/No _____	9) Communication barrier	Yes/No _____
4) Hearing impairment	Yes/No _____	10) Immune deficiency disorder	Yes/No _____
5) Developmental disability	Yes/No _____	11) Special Needs	Yes/No _____
6) Mental illness	Yes/No _____	12) Other, please list	

List Current Supportive Assistance: (Names of Persons/Organizations Providing Assistance)

1)	3)
2)	4)

Presenting Problem: Please describe the need for Senior Companion services:

#3-009 (2/2002)
#3-009(1/2014) LLO

Office Use Only
Referral status: Open/Closed
Date filled:

Note: Information is confidential, disclosure of stated information is for the sole purpose of obtaining SCP services.