

ShareCare Application

(updated: April 10, 2012)

Date: _____

Name _____ (circle) F M

Address _____

City _____ State _____ ZIP _____

Preferred Phone _____ Other Phone _____

E-mail _____ Birth Date: _____

Marital Status _____

Your home: Mobile home ____ Apartment ____ House ____

Does your home have stairs? Yes ____ No ____

Do you use: Wheelchair _____ Walker or Cane _____

Do you drive? Yes ____ No ____ Do you own a car? Yes ____ No ____

How did you hear about us? _____ Name of the person who invited you, if any:

List other people in your household, if any, and their relationship to you:

Do you have a disability? Yes No

If "yes," what is the nature of your disability (describe)?

List any allergies you may have (smoke, pets, etc.).

Does anyone in your household smoke? Yes _____ No _____

If you have pets please list: _____

What is your primary language? _____ Secondary? _____

Communication barriers for you or others in your household: (blind, deaf, ,etc.)

Are you a primary caregiver for someone who has a disability? Yes _____ No _____

If "no," skip to Personal Information section.

Care Recipient Information:

Name of Care Recipient _____ Gender F M

What is your relationship to care recipient?

What is the nature of their disability (describe)?

Major health issues of care recipient

Can care recipient be left alone? Yes No

Personal Information

Tell us a little about yourself and your hobbies/special interests:

Please list five services that you would most likely be able to provide to the group members.
We suggest you list things you like to do!

1. _____
2. _____
3. _____
4. _____
5. _____

Please list five services that you would like to receive from other members.

1. _____
2. _____
3. _____
4. _____
5. _____

Please mark with an "X" which times you are available:

Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

Morning							
Afternoon							
Evening							

Employment Information:

Current Employer

Address

Phone _____

Position/Title _____

Emergency Contact Information:

Name _____

Relationship _____

Phone Number(s)

Doctor's Name _____ Phone _____

References: Please list three people who can provide a reference for you. We must have contact information, because we do contact each of your references.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Information needed if you are providing transportation for others

Driver's License Number _____ State _____

Car Insurance Provider

Members are requested to make a contribution of **\$1.00 fee per month or \$11.00 per year (either at signup or annually in January).**

Please mail to: **ShareCare** c/o Bob Buckner
P.O. Box 687
Hattiesburg, MS 39403
Phone 601-466-9798

ShareCare Participant Agreement:

ShareCare is a community time bank designed to increase the involvement of its members in their community through reciprocal acts of kindness to improve the quality of life in our community.

I understand that participation in this program, either as a volunteer or a recipient, shall not be construed to mean that ShareCare and/or the member agencies accepts liability for claims, suits, judgments or damages arising from acts or failures to act by any volunteer or recipient in this program. I further understand that I am not an agent, servant, or employee of any of the participating agencies of this collaborative and that I am acting as an independent volunteer member with the ShareCare Bank.

I have read this document and understand its contents.

ShareCare Volunteer/Recipient:

X _____ Date _____

Photo Consent:

I consent to allow my interview(s), photography, videotaping, publication and exhibition to be used by ShareCare for public relations, news articles, telecasts, education, advertising, research, inclusion on the ShareCare Web site, fundraising, or any other purpose.

I waive all rights I may have to any claims for payment or royalties in connection with any of the above.

ShareCare Volunteer/Recipient:

Signature **X** _____ Date _____