ShareCare Bank
Application

Name ____ Gender (circle) F M

Address ____

City _____________________ State _____ ZIP _________ County _______________

Home Phone ________________________ Cell or Other Phone __________________

E-mail ____________________________ Race ______________________________

Date of Birth ________________________ Marital Status _______________________

List other people in your household and their relationship to you.

Name	*Relationship*
__________________________________	____________________________
__________________________________	____________________________
__________________________________	____________________________
__________________________________	____________________________

Do you have an ADA qualifying disability (see page 6)? (Circle**)** Yes No

Are you a primary caregiver for someone who has an ADA qualifying disability? Yes No

What is your relationship to care recipient? ____________________________________

Name of care recipient __________________________ Age ______ Gender F M

Major health issues of care recipient ____

Can care recipient be left alone? Yes No

Does care recipient require assistance with activities of daily living, such as eating or bathing? Yes No

If Yes, please explain. ____

____

List any allergies (smoke, pets, etc.). ______________________________________

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What is your primary language? ____________________ Secondary? _________________

List any communication barriers for you or someone in your household. _______________

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Does anyone in your household smoke? Yes No

Personal Information

Tell us a little about yourself and your hobbies/special interests. This information will be used to help us coordinate exchange of time and services.

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____

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							

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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.

Name	*Phone*
____________________________________	__________________________
____________________________________	__________________________
____________________________________	__________________________

Information for Providing Transportation

Driver's License Number ____________________________________ State ______

Car Insurance Provider ____

Background Check

Some members will provide respite care/sitting as a service. For everyone's security, we must have the ability to conduct background checks. This information will be kept confidential and will not be shared with anyone other than the staff of the Institute for Disability Studies and Campus Police at The University of Southern Mississippi. Campus Police will be conducting the background checks for the membership.

Your privacy is of utmost concern for us. Background checks are to protect YOU, as well as ALL members.

Please provide the following information and sign stating that you agree to have a background check done

Full Name ____

Date of Birth ____________________ Social Security Number ________________

Signature ____________________________________ Date ______________

ShareCare Bank Member Consent

I consent to the release of all relevant information concerning my ability and fitness to work for ShareCare Bank. I certify that the information given on this form is accurate to the best of my knowledge. **I also understand that, as a member of ShareCare Bank, we offer neighborly services to each other. Members provide services to the best of their ability and do not guarantee their work.** I acknowledge that any services I receive from ShareCare Bank may be terminated with or without notice, at any time, at the option of either ShareCare Bank or me.

Name____ Date ____________

Please return application to
ShareCare Bank
Institute for Disability Studies
118 College Drive #5163
Hattiesburg, MS 39406-0001

Christy.Harrison@usm.edu

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Institute for Disability Studies
The University of Southern Mississippi
Consent/Release Form

I consent to interview(s), photography, videotaping, publication, exhibition, or reproduction to be used for public relations, news articles or telecasts, education, advertising, research, inclusion on the IDS Web site, fundraising, or any other purpose by the Institute for Disability Studies and/or The University of Southern Mississippi.

I waive all rights I may have to any claims for payment or royalties in connection with any exhibition, televising, or other publication of these materials, regardless of the purpose or sponsoring of such exhibiting, broadcasting, or other publication irrespective of whether a fee for admission or film rental is charged. I also waive any right to inspect or approve any photo, video, or film taken by IDS or the person or entity designated by it.

All negatives and positives, whether prints, video, film, or sound recording are the property of IDS or the person or entity designated by it, solely and completely. I declare that I am eighteen (18) years old or older and am legally competent to execute this release or that I have acquired the written consent of my parent or guardian. I understand that the terms herein are contractual and not a mere recital, that this instrument is legally binding, and that I have voluntarily signed this document.

I have fully informed myself of this consent, waiver of liability, and release before signing it.

Name ____Date_____________

Address ____

City ____ State________ ZIP________

Phone Number(s) ____

Signature____

If under 18, the parent or legal guardian, if any, must sign.
Parent/Guardian

Name____

Address ____

City____ State______ ZIP_____________

Phone Number(s) ____

Signature of Parent/Guardian__________________________________ Date_____________

Witness Signature ____ Date_____________

Witness Name (please print)____

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Definition of ADA Qualifying Disabilities

An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered.

The first part of the definition makes clear that the ADA applies to persons who have impairments and that these must substantially limit major life activities such as seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working. An individual with a minor, non-chronic impairment of short duration, such as a sprain, broken limb, or the flu, generally would not be covered.

The second part of the definition protecting individuals with a record of a disability would cover, for example, a person who has recovered from cancer or mental illness.

The third part of the definition protects individuals who are regarded as having a substantially limiting impairment, even though they may not have such an impairment. For example, this provision would protect a qualified individual with a severe facial disfigurement from being denied employment because an employer feared the “negative reactions” of customers or co-workers.

For answers to additional questions, call the ADA Information Line at 1.800.514.0301 (Voice) or 1.800.514.0338 (TTY).