Jewish Family Service

YACHAD PROGRAM QUESTIONAIRE

Name: _____

1. What are the best hours for you to participate in a program? Check all that apply:

□ Sunday after 1:00pm

□ Weekday afternoons

□ Evenings please check preference 6pm_____ 7pm_____

Other_____

2. What are you favorite activities? _____

3. Would you like to learn about community volunteer opportunities? □ Yes □ No

4. What subjects would you like to learn about? Please write in your own ideas.
□ Community safety
□ Cooking
□ Gardening
□ Health education
□ Laundry and Home Care
□ Money management
□ Sports

5. Would you like more activities where transportation is provided? □Yes □ No

6. Because all members are not available to participate at the same times would you like more activities with smaller groups? □ Yes □ No

7. As a group we can celebrate the Holy Days in two ways please choose the best for you.

□ I want to attend Synagogue with the Yachad group

□ I would like to have a separate Holiday activity with Yachad and attend Synagogue with my family/friend.

Supports and Services

Name: _____

1. My living situation is:

□ My family home □ In the community □ In a facility

2. Are you receiving government financial support? □ No □ SSI □ SSA

3. Are you on the Medicaid Waiver waiting list? □ Yes □ No

*If yes, how long have you been on the list and what was your projected wait time before being accepted into the program? _____

4. Is it your goal to move into the community? □ Yes □ No □ Not Sure

5. If quality Housing was available when would you choose to move into the community?

□ Immediately

□ 3-6 months

□ 6 months to a year

□ Not sure

6. Do you have a person/agency that provides respite for you? □ Yes □ No

7. If yes which categories apply to the provider?

Friend/Family_____ paid_____ Not Paid_____
Professional_____
Funded by family_____
Funded by the State_____

In Case of Emergency Form:
This form will be kept confidential and be used only if an emergency situation deems it necessary. Completing this form is voluntary.

Name: _____
Address: _____
Home Phone: _____
Cell Phone: _____

1. Do you have a legal guardian? □ Yes □ No
If yes:
Name of Guardian:_____
Telephone numbers of guardian:
Home_____
Office_____
Cell:_____

2. Do you have a health Care Surrogate? □Yes □No

If yes please identify that individual
Name:_____
Phone: Home_____
Office_____
Cell_____

3. Do you have any allergies? (food or medication) □Yes □No
If yes please list

_____ _____
_____ _____
_____ _____

4. Do you have diabetes? □ Yes □ No

5. Do you have seizures? □ Yes □ No

Additional Comments: