



BETTER TOGETHER NEIGHBOR APPLICATION

First Name		Last Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City		State	Zip
Home Phone	Cell Phone	Email		Prefer calls in: <input type="checkbox"/> AM <input type="checkbox"/> PM	
Specific Directions to Home					
Do you live alone? Yes <input type="checkbox"/> No <input type="checkbox"/>	Who do you live with (name)?		Relation		
Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>	Any smokers in your home? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a pet? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name and Type of Pet		
Occupation/Previous Occupation		Primary Language		# of Years living in Sioux Falls	
Have you ever been convicted of a drug charge?		Yes <input type="checkbox"/> No <input type="checkbox"/> Charge: _____ Year: _____			
Have you ever been convicted of a criminal offense?		Yes <input type="checkbox"/> No <input type="checkbox"/> Charge: _____ Year: _____			
Have you ever been convicted of abuse, neglect, or assault?		Yes <input type="checkbox"/> No <input type="checkbox"/> Charge: _____ Year: _____			
How is your...					
Hearing <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Need/Use Hearing Aids <input type="checkbox"/> Deaf					
Vision <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Need/Wear Glasses <input type="checkbox"/> Blind					
Mobility <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Walks Alone <input type="checkbox"/> Walk with Assistance/Walker <input type="checkbox"/> Wheelchair					
Any concerns to note:					
Preference for Match					
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Couple <input type="checkbox"/> Family with Older Children <input type="checkbox"/> Family with Small Children <input type="checkbox"/> Small Group <input type="checkbox"/> No Preference					
How did you hear about the program? Check as many as apply.					
<input type="checkbox"/> LSS <input type="checkbox"/> Radio <input type="checkbox"/> Attended Event <input type="checkbox"/> Letter <input type="checkbox"/> Church					
<input type="checkbox"/> Apartment Manager <input type="checkbox"/> Television <input type="checkbox"/> Doctor <input type="checkbox"/> Newspaper <input type="checkbox"/> Web/Social Media					
<input type="checkbox"/> Person: _____ <input type="checkbox"/> Other: _____					
Emergency Contact Name		Emergency Contact Number		Relation	

I am available the following days/times:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

I would like to meet Once per week Every other week Once or twice per month No Preference

I am interested in participating in monthly events organized by LSS? Yes No On occasion Not sure

Please list any other information about yourself you feel would be helpful in matching you. This can include any special hobbies, talents, or interests.

Please describe a few things you would like to do when participating in this program.

Why are you interested in participating in this program?

Any issues of concern to note (family history, physical/mental health issues, health conditions)?

What other community programs are you involved in or what community services do you receive (Meals on Wheels, Service Club, Church, Social Worker, Senior Companion, etc)?

Please Return Complete Form To:
LSS Mentoring Services – Better Together Program
621 E Presentation Street, Sioux Falls, SD 57104
Phone: 605-221-2403
Fax: 605-221-2404
Email: Mentoring@LssSD.org
www.LssSD.org