**Caregiver Respite/Supplemental Services/Case Management Assessment**

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. We ask for demographic information to meet requirements from our funders. All your personal information is confidential. Please see the attached FAQs for more information and guidance on filling out this form.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Caregiver Contact & Demographic Information:** | | | | |
| **First Name:** |  | **Middle Name:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** |  | **Nickname:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Birth:** | | | |  | | | | | | **Age:** |  | |
| **Home Address** Line 1: | | | | | |  | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | |  | | | | City: | |  | | |
| Zip: |  | | County: | | | |  | | | | | | State: |  |
| **Mailing Address** Line 1: | | | | | |  | | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | |  | | | | City: | |  | | |
| Zip: |  | | County: | | | |  | | | | | | State: |  |

|  |
| --- |
| **Location Comments** (additional directions for home or mailing address): |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Home Phone:** | |  | **Cell Phone:** |  |
| **Email:** |  | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender:** | Male | Female | Non-Binary/Third Gender |  |

**Identify as:**  Transgender  Cisgender (identify with your gender from birth)

|  |  |  |  |
| --- | --- | --- | --- |
| Gender not listed: | |  | |
| **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino | | | | |
| **Race, select all that apply:** | | | | |
| American Indian or Alaska Native | | | | Middle Eastern or North African |
| Asian or Asian American | | | | Native Hawaiian or Pacific Islander |
| Black or African American | | | | White |
| Race not listed: | |  | | |

**Do you live:**  Alone  With Others  **Are you a veteran?** Yes  No

|  |  |
| --- | --- |
| **Number of people in your household** (including you): |  |

**Is your income above or below the amount listed for your household size:**

Above  At/Below

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,132.00 | $13,590.00 |
| 2 | $1,526.00 | $18,310.00 |
| 3 | $1,919.00 | $23,030.00 |
| For each additional person, add $4,720 to annual income | | |

|  |
| --- |
| **Communication & Service Needs:** |

**Would you like to hear about other services?** Yes  No

**If yes, how can we contact you?**  Email  Mail  Phone

|  |
| --- |
| **Caregiver/Care Recipient Relationship Information:** |

*Please provide information for each individual care recipient you care for.* ***If the care recipient is an adult (18+), please also complete an In-Home Assessment Form.***

**Care Recipient Information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** | | |  | |
| **Date of Birth:** | |  | | **Age:** |  | |

**Lives with caregiver?**  Yes  No (if no, please provide their home address)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Home Address Line 1: | | | |  | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | |  | | | City: |  | | |
| Zip: | |  | County: | | |  | | | State: |  |

**Caregiver’s Relationship to Care Recipient:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Husband | | Wife | Domestic Partner |  |  |  |
| Son/Son-in-Law | | Daughter/Daughter-in-law | Sister |  |  |  |
| Brother | | Grandparent | Parent |  |  |  |
| Other Relative: |  | | |  |  |  |
| Non-Relative: |  | | |  |  |  |

|  |
| --- |
| **Caregiver Assessment - Additional Questions:** |

**Which types of caregiver services are you interested in? Select all that apply:**

Information about services

Counseling

Education/Training

Support Groups

Meals (delivered to your home or dining at a community site)

Transportation

Supplies to assist with caregiving duties (e.g. food, assistive devices)

Respite Care (in-home or out-of-home supports/arrangements to provide caregivers temporary break from caregiving duties)

Adult day care programs for care recipients

Resources for grandparents raising grandchildren

|  |  |
| --- | --- |
| Other (please explain): |  |
|  | |

**What type(s) of assistance do you provide to the care recipient? Select all that apply:**

|  |  |  |
| --- | --- | --- |
| Hygiene (bathing, grooming, etc.) | | Transportation |
| Dressing | | Errands/Shopping |
| Eating/Feeding | | Maintenance of Home/Yard |
| Meal Preparation | | Housekeeping and Laundry |
| Using the bathroom/incontinence | | Managing Finances/Paying Bills |
| Getting around the home | | Administering Medication |
| Getting in/out of beds and chairs | | Medical Treatment/Managing Condition(s) |
| Other (please explain): |  | | |
|  | | | |

**Are you getting help from anyone with your caregiver duties?**

Yes - professional/paid (formal) help

Yes - informal help

Yes - both formal and informal help

No

|  |  |
| --- | --- |
| **If yes, please explain:** |  |
|  | |

**What is your employment status?**

Retired  Employed full-time  Employed part-time  Unemployed  On Leave

|  |  |
| --- | --- |
| Other (please explain): |  |

**Disclosures and Waivers**

*I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

***For Office Use Only –***

*(If filled out by assessor or via phone, please have assessor check here and sign below* )

|  |  |  |  |
| --- | --- | --- | --- |
| **Filled Out By:** |  | **Date:** |  |

**Caregiver Services Eligibility:**

|  |  |
| --- | --- |
| **Family Caregiver of an Older Adult** | **Care Recipient** |
| An adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to the Care Recipient | An older individual (60 years of age or older) *or*  An individual (age < 60) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction |

|  |  |
| --- | --- |
| **Older Relative Caregiver/Grandparent of a Child** | **Care Recipient** |
| A grandparent, step-grandparent, or other older relative of the child by blood, marriage, or adoption who is at least 55 years old living with the child, and identified as the primary caregiver through a legal or informal arrangement | A child (less than 18 years old)  *or*  An individual (18 to 59 years old) with a disability |