**Caregiver Counseling/Training/Support Groups 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 | $1,215.00 | $14,580.00 |
| 2 | $1,643.00 | $19,720.00 |
| 3 | $2,072.00 | $24,860.00 |
| For each additional person, add $5,140 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

|  |  |
| --- | --- |
| **What services are you interested in?** |  |
|  | |

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

*Please provide information for each individual care recipient you care for:*

**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: |  | | |  |  |  |

**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 |