

SECTION 1 – Service Information

Provider Name: (SAMPLE 7, Title III E, Caring for Elderly)	Registration/Assessment Date:
Region/Site Name:	*Termination Date: *Reason:

Title III E, Family Caregiver Support Program Services To Be Provided			
Support Services:	<input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Caregiver Support	Respite Care Services:	<input type="checkbox"/> In-Home Supervision
<input type="checkbox"/> Caregiver Counseling	<input type="checkbox"/> Caregiver Training	<i>(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)</i>	<input type="checkbox"/> Homemaker Assistance
<input type="checkbox"/> Caregiver Peer Counseling	<input type="checkbox"/> Case Management		<input type="checkbox"/> In-Home Personal Care
			<input type="checkbox"/> Home Chore
			<input type="checkbox"/> Out of Home Day
			<input type="checkbox"/> Out of Home Overnight
Supplemental Services: <i>(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)</i>			
<input type="checkbox"/> Assistive Devices <input type="checkbox"/> Home Adaptations for Caregiving <input type="checkbox"/> Caregiving Services Registry <input type="checkbox"/> Cash/Material Aid			
Access Assistance:		Information Services:	
<input type="checkbox"/> Information & Assistance	<input type="checkbox"/> Caregiver Outreach	<input type="checkbox"/> Public Information on Caregiving	
<input type="checkbox"/> Interpretation/Translation		<input type="checkbox"/> Community Education on Caregiving	
<input type="checkbox"/> Caregiver Legal Resources			

SECTION 2 – Eligibility Criteria

Caregiver Caring for Elderly Eligibility Criteria
1. Is the Care Receiver an older individual (60 years of age or older) <u>or</u> an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the Caregiver 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 an "elderly" Care Receiver? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregiver Caring for Elderly services, but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (FCSP Caregiver)
(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please Print):					
*Unique Participant ID					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
Last 4 Digits Social Security # <i>Optional</i>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> <td style="width: 25%;"></td> </tr> </table>				
Home Phone #:	()				
Residential Address:					
Street:					
City:					
*Zip Code:					

Mailing Address:	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> At or below FPL <input type="checkbox"/> Above FPL <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race	
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
*Relationship to Care Receiver	<input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Grandparent <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other Relative <input type="checkbox"/> Daughter/Daughter-in-law <input type="checkbox"/> Son/Son-in-law <input type="checkbox"/> Non Relative <input type="checkbox"/> Declined to State
*Relationship Status:	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
*Employment:	<input type="checkbox"/> Full Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Part Time <input type="checkbox"/> Declined to State <input type="checkbox"/> Retired

SECTION 4 (Care Receiver)
 (*) Required for Family Caregiver Support Program Services

*Unique Participant ID:					
Care Receiver Personal Data (Please Print):					
First Name:					
Middle Initial:					
Last Name:					
* What is your gender? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
* What was your sex at birth? (Check only one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined/not stated				
* How do you describe your sexual orientation or sexual identity (Check only one)	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Not Listed, please specify: _____ <input type="checkbox"/> Declined/not stated				
*Birth Date:					
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Home Phone #:	()				
Residential Address:					
Street:					
City:					
*Zip Code:					

Mailing Address:	
Same As Residential? <input type="checkbox"/> Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
*Ethnicity:	<input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Declined to State
*Federal Poverty Level (FPL)	<input type="checkbox"/> Yes (At or below FPL) <input type="checkbox"/> No (Above FPL) <input type="checkbox"/> Declined to State
*Lives Alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Rural?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to State
*Race: (Please Check ONE)	
<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other Race <input type="checkbox"/> Multiple Race Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Declined to State	
*Relationship Status:	<input type="checkbox"/> Single (never married) <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State

SECTION 5 (Care Receiver)

***ADLs & IADLs (Activities of Daily Living & Instrumental Activities of Daily Living)**

Required for Support Services, Respite Care, and Supplemental Services.

Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLS	Rated Value	RATING SCALE 1 = Independent 2 = Verbal Assistance 3 = Some Human Help 4 = Lots of Human Help 5 = Dependent 6= Declined to State
Feeding		Meal Preparation		Light Housework		
Dressing		Shopping		Heavy Housework		
Bathing		Manage Medication		Notes:		
Transferring In/Out of Chair		Money Management				
Walking		Telephone				
Toileting		Transportation				