Larimer County Office on Aging

Family Caregiver Support Program Assessment

Caregiver's Profile

Caregiver's Contact Information

Name: _____ (First) _____ (Last) _____ (Middle Initial) Birth Date: __/__/__ Age: _____

Gender: _____ Preferred Language: _____

If you live alone, is your individual monthly income below $1,012? ☐ Yes ☐ No

If you have a spouse or partner, is your monthly household income below $1,372? ☐ Yes ☐ No

Veteran status: Caregiver ☐ Yes ☐ No Care Receiver ☐ Yes ☐ No

If so, are either you or the care receiver accessing VA benefits? ☐ Yes ☐ No

Living Situation: ☐ Own ☐ Rent ☐ Alone ☐ Rural/Remote ☐ Homebound
(Please check all that apply) ☐ Other _____ *(Please specify)*

Number in household _____

Best way to contact you: ☐ Mail ☐ Phone ☐ Email

Address: _____ (Street) _____ (Apt #) _____ (County)

_____ (City) _____ (State) _____ (ZIP code)

Mailing Address: *(If different from above)* _____ (Street) _____ (Apt #) _____ (County)

_____ (City) _____ (State) _____ (ZIP code)

Phone: _____ Email: _____

Alternate Phone:

Marital Status

☐ Married ☐ Partnership ☐ Living Together ☐ Divorced ☐ Widowed ☐ Single

Race or Ethnicity

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Latino/a ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Employment

Current Employment: ☐ Self ☐ Full- Time ☐ Part- Time ☐ Volunteer ☐ Retired

Has your caregiving role interfered with your employment? ☐ Yes ☐ No

If so, how?

Health Concerns

Are you experiencing any: ☐ Problems sleeping ☐ Hearing problems
☐ Vision problems (cannot be corrected by glasses)

Other medical concerns? Any change in the past 6 months? ☐ Yes ☐ No

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Caregiving Situation

Name of person you are providing care to: _____ First _____ Last _____ Middle Initial

Relationship to this person: ☐ Spouse ☐ Daughter ☐ Son ☐ -In law ☐ Friend ☐ Other: _____ *(Please specify)*

Do you live with person you are caregiving for? ☐ Yes ☐ No

How long have you been in the "caregiving" role? _____

Typically for how many hours a week? _____ hours/week (i.e. 168 hours = 24hr./7 days)

Do you provide care for any additional individuals? ☐ Yes ☐ No

If so, who? _____

Is there anyone else providing help to the care receiver? ☐ Yes ☐ No

If so, who? _____

Caregiver Resources

How confident do you feel in providing the care you need to?

☐ Very ☐ Fairly ☐ Just a little ☐ Not at all

What types of resources would be the most useful for you at this time?
(Please check all that apply)

<u>Educational Resources</u>

- ☐ Chronic disease management
- ☐ Behavior management (i.e. resisting care)
- ☐ Caring for yourself (i.e. strain)
- ☐ Dementia resources (i.e. communication)

<u>In-home Services</u>

- ☐ Care receiver's personal care
- ☐ Household chores
- ☐ Home safety (i.e. assisted devices)
- ☐ Medical care tasks (i.e. medication management)

<u>Ability to Discuss Caregiving Experiences</u>

- ☐ Individual counseling
- ☐ Support groups

<u>Legal or Financial Resources</u>

- ☐ Advance directives (i.e. Powers of Attorney)
- ☐ Financial/ benefits planning (i.e. Medicaid)

<u>Community Resources</u>

- ☐ Transportation
- ☐ Meal delivery
- ☐ Adult day programs
- ☐ Assisted living or nursing facilities
- ☐ Additional resources: _____

Caregiver's Profile

What do you do to take care of yourself? (i.e. hobbies, exercise, leisure activities, support groups)

Briefly describe what strengths you bring to your caregiving?

What are some concerns or issues you have in your caregiving role?

What are some of the most difficult tasks for you in your caregiving role?

What is most important to you during this time of caregiving?

Caregiver's Profile

How did you hear about the Family Caregiver Support Program?

Caregiver Consultation:

A caregiver consultation is a personal visit with you individually, you and the person you care for, and/or with you other members of your family. This serves as a time to:

- Answer caregiving questions
- Create a plan that lifts some of the strain/stress of caring for someone else
- Promote and encourage self-care

☐ **Please check if you are interested in a consultation.**

Respite Care

All caregivers need an occasional break from the demands of caring for someone else. Respite care will help you- and the person you care for. Respite care includes:

- Care at home, daily care outside the home (i.e. adult day program), or overnight care at an assisted living or skilled nursing facility for a number of days
- Care can be provided by homecare agencies, private caregivers or arranged through family and friends

Caregiver Respite Voucher:

A respite voucher may be available to help you purchase in-home services or other types of respite care personally suited to you and the person you care for.

☐ **Please check if you are interested in applying for the voucher.**

Please describe, being as specific as possible, how you plan to use the voucher to give yourself an occasional break and/or some back-up support:
What would be the first step in this plan? This week I will...

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 providers and I hereby give my consent to do so. I certify that the information provided on this document is true and accurate to the best of my knowledge.

Caregiver Signature _____ ***Date*** ___/___/___

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Care Receiver's Profile

Please fill out the information below about the person you care for.

Care Receiver's Contact Information

Name: _____ (First) _____ (Last) _____ (Middle Initial)

Birth Date: / /

Age: _____

Gender: _____ Preferred Language: _____

Living Situation: *(Please check all that apply)*
☐ With Family Member ☐ Care Facility ☐ Alone ☐ Rural/Remote
☐ Homebound ☐ Other _____ *(Please specify)*

Address: *(If different from caregiver)*
_____ (Street) _____ (Apt #) _____ (County)
_____ (City) _____ (State) _____ (ZIP code)

Phone: Email:

Marital Status

☐ Married ☐ Partnership ☐ Living Together ☐ Divorced ☐ Widowed ☐ Single

Race or Ethnicity

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Latino/a ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Programs & Services

Does the care receiver currently have advance directives (i.e. POA, Living Will)? ☐ Yes ☐ No

Care receiver's monthly gross income: *(Monthly income before taxes)*
☐ $1,012 or below ☐ $1,013 to $1,265
☐ $1,266 to $1,871 ☐ $1,872 or more

Care receiver's and spouse monthly gross income: *(Monthly income before taxes)*
☐ $1,372 or below ☐ $1373 to $1,715
☐ $1,716 to $2,538 ☐ $2,539 or more

Do you or the care receiver participate in? *(Please check all that apply)*
☐ Long Term Care Medicaid/ Home and Community Based Service
☐ Medicare ☐ SSI/SSDI/ Disability benefits

Are there any additional programs or services you or the care receiver participates in?

Medical Information

Primary diagnosis: _____

Is there a dementia related diagnosis? ☐ Yes ☐ No

Is the care receiver experiencing any: ☐ Problems sleeping ☐ Hearing problems
☐ Vision problems (cannot be corrected with glasses)

Other medical concerns?

Have any of these concerns or problems changed in the past 6 months? ☐ Yes ☐ No

Care Receiver's Profile

Please check how much assistance you or another person provides for the care receiver with the activities of daily living below:	No assistance (0)	Occasional assistance (1)	Unable to do without assistance (2)
Eating (not preparation of food)	☐	☐	☐
Dressing	☐	☐	☐
Bathing or showering	☐	☐	☐
Getting to & using the toilet	☐	☐	☐
Getting in & out of bed	☐	☐	☐
Mobility around the home	☐	☐	☐
Managing personal care needs (i.e. incontinence products)	☐	☐	☐
Do you provide supervision for the care receiver due to memory or behavioral concerns?	☐ Yes ☐ No		

Please check how much assistance you provide or another person for the care receiver with the instrumental activities of daily living below:	No assistance (0)	Occasional assistance (1)	Unable to do without assistance (2)
Managing financials or bills	☐	☐	☐
Shopping	☐	☐	☐
Managing medical tasks (i.e. medication)	☐	☐	☐
Preparing meals	☐	☐	☐
Completing ordinary housework (i.e. laundry, vacuuming)	☐	☐	☐
Using the telephone	☐	☐	☐
Providing or accessing transportation	☐	☐	☐

Please check all specific medical tasks you assist the care receiver with:

- ☐ Prescribed medications
- ☐ Oxygen
- ☐ Scheduling/attending medical appointments
- ☐ Wound care/blood sugar testing, etc.
- ☐ Over-the-counter medication
- ☐ Pain management
- ☐ Medical billing/insurance
- ☐ Other:

Please check any of the below reactions you have experienced from the care receiver:

- ☐ Restlessness
- ☐ Suspicion
- ☐ Losing or hiding items
- ☐ Incontinence
- ☐ Aggression
- ☐ Following
- ☐ Appearing sad
- ☐ Exit-seeking

Care Receiver's Profile

Please check if the below statements about nutrition are true <u>for the care receiver ("I")</u>:	Yes	No	*Score*
I have an illness or condition that made me change the kind and/or amount of food I eat.	☐	☐	*2*
I eat fewer than two meals a day.	☐	☐	*3*
I eat few fruits, vegetables or dairy products.	☐	☐	*2*
I have 3 or more drinks of beer, liquor, or wine almost every day.	☐	☐	*2*
I have tooth or mouth problems that make it hard for me to eat.	☐	☐	*2*
I don't always have enough money to buy the food I need.	☐	☐	*4*
I eat alone most of the time.	☐	☐	*1*
I take 3 or more different prescribed or over the counter drugs a day.	☐	☐	*1*
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐	☐	*2*
I am not always physically able to shop, cook and/or feed myself.	☐	☐	*2*
Are you interested in receiving nutrition counseling?	☐	☐	

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 providers and I hereby give my consent to do so. I certify that the information provided on this document is true and accurate to the best of my knowledge.

Care Receiver Signature _____ *Date* ___/___/___

Signature of Legal Representative or Guardian _____ *Date* ___/___/___

Please return "Caregiver's Profile" and "Care Receiver's Profile" to:

<u>Mail</u>: Larimer County Office on Aging, Attn: Lynette McGowan
1501 Blue Spruce Drive, Fort Collins, Colorado 80524
<u>Fax</u>:(970) 498-6304, Attn: Lynette McGowan
<u>Email</u>: lmcgowan@larimer.org

Any questions please call Lynette McGowan, Caregiver Support Program Coordinator at the Larimer County Office on Aging at (970) 498-7758