



Caregiver- Respite Voucher Assessment Form

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.

Have you previously been issued a respite voucher? ☐ Yes ☐ No Date: _____

Caregiver Contact & Demographic Information:

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____

Gender/Identity: ☐ Male ☐ Female ☐ Gender/identity not listed: _____

Marital Status:

☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Home Address: _____

(Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address: _____

(Apt/Unit/Floor #): _____ City: _____

Zip: _____ County: _____ State: _____

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

Home Phone: _____ Cell Phone: _____

Email: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Are you a veteran? ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race, select all that apply:

☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander

☐ Asian or Asian American ☐ White

☐ Black or African American ☐ Other not listed: _____

Number of people in your household (including you): _____

Is your individual income above or below \$1073 per month? ☐ Above ☐ At/Below

Care Recipient Information:

First Name: _____ **Last Name:** _____

Caregiver's relationship with Care Recipient:

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: _____

Additional Caregiver Information:

Do you receive benefits from any of the following programs?

☐ Long Term Care Medicaid/HCBS ☐ VA Benefits ☐ Medicare ☐ Medicaid

Best way to contact you? ☐ Email ☐ Phone

How did you hear about this program? _____

How long have you been the caregiver role? _____

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

Are you getting help from anyone with your caregiver duties? ☐ Yes ☐ No

If yes, please explain who: _____

Other medical concerns effecting your caregiver responsibility:

Do you use any assistive devices? Select all that apply:

☐ Walker ☐ Wheelchair ☐ Cane ☐ Crutches ☐ Electric Scooter

☐ Other: _____

Are you a grandparent raising grandchildren? ☐ Yes ☐ No

Are you working?

☐ Full-time ☐ Part-time ☐ Retired ☐ Volunteer ☐ Seeking employment ☐ No

Interest in Other Services:

What caregiving issues are you are struggling with/what supports do you need?

☐ Counseling ☐ Adult Day Care ☐ Education/Training

☐ Information about services ☐ In-home care ☐ Respite

☐ Personal care ☐ Supplemental services ☐ Support groups

☐ Other (please explain): _____



Are you interested in learning about nutrition and a healthy diet? ☐ Yes ☐ No

Are you interested in hearing about other caregiver services? ☐ Yes ☐ No

Are you interested in receiving email updates with upcoming resources or classes? ☐ Yes ☐ No

Can you perform chore activities without help? ☐ Yes ☐ No

Comment on what support is needed for chore services:



Care Recipient – Respite Voucher Assessment Form

Please fill out the information below in regard to the individual you are providing care for. For questions “you” is used, the title “care recipient” would be appropriate.

Contact & Demographic Information for Care Recipient

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Age: _____

Gender/Identity: ☐ Male ☐ Female ☐ Gender/identity not listed: _____

Home Address: _____

Apt/Unit/Floor #: _____ City: _____

Zip: _____ County: _____ State: _____

Mailing Address: _____

Apt/Unit/Floor #: _____ City: _____

Zip: _____ County: _____ State: _____

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

Home Phone: _____ Cell Phone: _____

Email: _____

Primary language: ☐ English ☐ Spanish ☐ Other: _____

Are you a veteran? ☐ Yes ☐ No Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race, select all that apply:

☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander

☐ Asian or Asian American ☐ White

☐ Black or African American ☐ Other not listed: _____

Number of people in your household (including you): _____

Is your individual income above or below \$1073 per month? ☐ Above ☐ At/Below

Do you receive benefits from any of the following programs?

☐ Long Term Care Medicaid/HCBS ☐ VA Benefits ☐ Medicare ☐ Medicaid

Do you currently have any advance directives (i.e POA)? ☐ Yes ☐ No

Emergency Contact:

Primary Emergency Contact:

Name: _____

Phone: _____ Relationship: _____

Nutrition Screening for Care Recipient:

Determine your nutritional health. If the statement is true for you, check the box in the “Yes” column and add the points in the “Yes Score” column to your total score.

Nutrition Risk Score Questions	Yes	No	Yes Score
Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you eat fewer than 2 meals per day?	<input type="checkbox"/>	<input type="checkbox"/>	3
Do you eat few fruits, vegetables, or milk products?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	<input type="checkbox"/>	<input type="checkbox"/>	2
Do you have tooth or mouth problems that make it hard for you to eat?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you do not have enough money to buy the food you need?	<input type="checkbox"/>	<input type="checkbox"/>	4
Do you eat alone most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	1
Do you take 3 or more different prescribed or over the counter drugs a day?	<input type="checkbox"/>	<input type="checkbox"/>	1
Without wanting to, have you lost or gained 10 pounds in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	2
Are there times you're physically unable to shop, cook, and/or feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	2
Total Nutrition Risk Score	Total “Yes” Score:		

Total Nutrition Risk Score: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – take action! Speak with a qualified health or social service professional about your nutritional health.

Activities of Daily Living and Instrumental Activities of Daily Living for Care Recipient:

Activities of Daily Living (ADLs)	Yes	No
I can bathe myself without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can dress myself without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can get around inside my home without help.	<input type="checkbox"/>	<input type="checkbox"/>

I can use the toilet without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can eat without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can get in and out of bed/chairs without help.	<input type="checkbox"/>	<input type="checkbox"/>
ADL Count (total “No” score):		

Instrumental Activities of Daily Living (IADLs)	Yes	No
I can manage money without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can take care of shopping without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can take my medication without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can prepare meals without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can do ordinary housework without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can use the telephone without help.	<input type="checkbox"/>	<input type="checkbox"/>
I can use transportation without help.	<input type="checkbox"/>	<input type="checkbox"/>
IADL Count (total “No” score):		

Comments on ADLs/IADLs: _____

Are you receiving assistance with ADLs or IADLs from anyone? ☐ Yes ☐ No

If yes, who is assisting you: _____

Care Recipient Health Conditions

Primary Diagnosis: _____

Other medical diagnoses or concerns: _____

Is substantial supervision provided by a caregiver due to memory or behavioral concerns? ☐ Yes ☐ No

Do you have any of the following?

☐ Autism ☐ Epilepsy/Seizure disorder ☐ Intellectual disability ☐ Diabetes
☐ Other: _____

Do you use any assistive devices? Select all that apply:

☐ Walker ☐ Wheelchair ☐ Cane ☐ Crutches ☐ Electric Scooter
☐ Other: _____

Do you use oxygen? ☐ Yes ☐ No

Do you use incontinence supplies? ☐ Yes ☐ No

Other Eligibility Criteria:

Do you require a Home Health Aide based on physician's orders? ☐ Yes ☐ No

Can you perform chore activities without help? ☐ Yes ☐ No

Comment on what support is needed to for chore services:

Do you have cognitive impairment? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Respite Voucher Information:

If you are interested in applying for a respite voucher, please provide specific information on how you plan on using this to give yourself an occasional break or increase support to you?

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:** _____



Client Information and FAQs Sheet

We are so glad you found us! Please keep this information for your records.



Provider and Area Agency on Aging Information:

Your local Area Agency on Aging: *Larimer County Office on Aging.*

Located in the Department of Human Service, Aging and Adult Service Department.

What is an Area Agency on Aging?

We're glad you asked! The Area Agency on Aging (AAA) is a regional agency that is designated by the state to administer federal, state, and local funding to meet the needs of older adults in their community. The AAA provides programs and services to older adults and caregivers directly and through contracts with community provider agencies. AAAs also serve as advocates for older adults.

Service Information:

The service you are requesting is funded through the Older Americans Act (OAA) and/or Older Coloradans Act (OCA) funding. This federal and state funding helps older adults, 60+, remain in their homes and communities of choice. Requests for services are processed as funds allow. We can provide you with referrals to other resources in your area, but we will not reach out to them without your permission.

What is the purpose of this form?

We ask you to fill-in this form for several reasons:

- To help us learn about you so we can offer services that best meet your needs
- To help us understand the needs of older adults in our community
- To help us show the need for funding our programs
- To help us meet reporting requirements from our funders

Taxpayer money funds these programs. We must prove that the funding only serves eligible clients and targets older adults and caregivers most in need of services. This paperwork helps us meet that level of accountability.

Income information is not used to determine your eligibility for services. Income and other demographic information (e.g. gender, race, ethnicity) are collected for anonymous demographic reporting purposes. None of your personal information, such as your name or date of birth is disclosed in reporting. You have the right to refuse to provide any of the information requested on the form.

What happens with my information?

We enter your information into a secure state database. As you receive services, we record the services you received in the database. This helps us prove how we spent the funding. The database is secured to the standards outlined in Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH). This means your data remains safe and confidential.

Will you sell my information?

No. We will never sell your information.

How do I provide feedback?

We love hearing how we can improve. Contact your service provider or your local Area Agency on Aging at 970-498-7750 or adrc@larimer.org. Because we value your input, we may at times send you a survey to ask for your feedback.

How do I file a complaint, grievance, or appeal?

Complaint/Grievance/Appeal Procedure:

You have the right to file a complaint or grievance with the organization asking you to fill out this form. If you are not satisfied with the organization's decision, you can appeal the decision to your local Area Agency on Aging (AAA), and/or the State Unit on Aging (SUA). The complete Complaint/Grievance/Appeal Procedures are available upon request by contacting your local AAA and/or the SUA as follows:

<p>Larimer County Office on Aging 1501 Blue Spruce Dr. Fort Collins, CO 80524 970-498-7750 adrc@larimer.org</p>	<p>Colorado Department of Human Services, State Unit on Aging 1575 Sherman Street, 10th Floor Denver, CO 80203 303.866.2800</p>
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Can I make a donation?

We accept donations and gifts to contribute towards the cost of services and to support our efforts. Every dollar we receive goes back into the programs and services.

Donations are voluntary and are not required to receive services.

You can send donations directly to your service provider or to the local Area Agency on Aging at the address above.

What other resources are available?

Feel free to reach out to your Area Agency on Aging to get more information about the services available in your region. We love to help!

Please visit our website <https://www.larimer.org/humanservices/aging/ooa> or contact us at 970-498-7750 and adrc@larimer.org.

You can also call the statewide Aging and Disability Resources for Colorado (ADRC) for information about resources in your area: 1-844-COL-ADRC / 1-844-265-2372

How can I help?

We couldn't meet the needs of older adults in our communities without the amazing help from volunteers and members of our Regional Advisory Councils. Reach out to either your provider or your AAA to see how you can help make a difference in the lives of older adults in our community.