**Evaluación del Cuidador- Asesoramiento/Formación/Grupos de Apoyo**

¡Bienvenido! Cuéntenos un poco sobre usted para que podamos ofrecerle los servicios que mejor se adapten a sus necesidades. Pedimos información demográfica para cumplir con los requisitos de nuestros financiadores. Toda su información personal es confidencial. Consulte las preguntas frecuentes que se incluyen para obtener más información y orientación sobre cómo llenar este formulario.

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| **Contacto e Información Demográfica:** |

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| --- | --- | --- | --- | --- |
| **Nombre:** |  | **Segundo Nombre:** | |  |
| **Apellido:** |  | | **Apodo:** |  |

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| **Fecha de nacimiento:** | | | | | |  | | | | **Edad:** |  | |
| **Dirección particular** Línea 1: | | | | | |  | | | | | | | | | |
| Línea 2 (n.º de apto./unidad/piso): | | | | | | |  | | | Ciudad: | |  | | |
| C.P.: |  | Condado: | | |  | | | | | | | Estado: |  |
| **Dirección postal** Línea 1: | | | | | |  | | | | | | | | | |
| Línea 2 (n.º de apto./unidad/piso): | | | | | | |  | | | Ciudad: | |  | | |
| C.P.: |  | Condado: | | |  | | | | | | | Estado: |  |

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| --- | --- | --- |
| |  |  | | --- | --- | | **Dirección postal Igual que la dirección de casa** |  |   **Inicio ubicación comentarios** (indicaciones adicionales sobre la dirección particular o postal): |
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| --- | --- | --- | --- | --- |
| **Teléfono particular:** | |  | **Teléfono celular:** |  |
| **Correo electrónico:** |  | | | |

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| **Género:**  Masculino  Femenino  No binario/Tercer género |

**Me identifico como:**  Transgénero  Cisgénero (identificarse con su género al nacer)

|  |  |
| --- | --- |
| Género, si no indicado: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Origen étnico:**  Hispano o latino  No hispano ni latino | | | |
| **Raza, marque todo lo que corresponda:** | | | |
| Indígena americano o Nativo de Alaska | | Del Oriente Medio o Del Norte de África | |
| Asiático o Asiático estadounidense | | Nativo de Hawaii o Isleño del Pacífico | |
| Negro o Afroamericano | | Blanco | |
| Raza, si no indicada: |  | | |
| **Vive:**  Solo  Con otras personas | | | | |
| **Número de personas que viven en su hogar** (incluido usted): | | | |  |

**¿Sus ingresos son superiores o inferiores a la cifra establecida para el tamaño de su hogar?**

Superiores  Iguales/Inferiores

|  |  |  |
| --- | --- | --- |
| Tamaño del grupo familiar | Ingresos mensuales | Ingresos anuales: |
| 1 | $1,255.00 | $15,060.00 |
| 2 | $1,703.00 | $20,440.00 |
| 3 | $2,152.00 | $25,820.00 |
| Por cada persona adicional, agregue $5,380 a los ingresos anuales | | |
|  | | |

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| **Necesidades de Comunicación y Servicios:** |

**¿Desea conocer otros servicios?**  Sí  No

**En caso afirmativo, ¿cómo podemos ponernos en contacto con usted?**

Correo electrónico  Correo postal  Teléfono

|  |  |
| --- | --- |
| **¿Qué servicios le interesarían?** |  |
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| **Información sobre la Persona que Recibe Cuidado:** |

*Por favor, proporcione la información de cada persona que recibe atención que esté bajo su cuidado.*

**Información sobre la persona que recibe cuidado:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Nombre:** |  | | **Apellido:** | | |  | |
| **Fecha de nacimiento:** | |  | | **Edad:** |  | |

**¿Vive con el cuidador?**  Sí  No (Si respondió "no", indique su domicilio)

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| Línea 1 para el domicilio: | | |  | | | | | | | |
| Línea 2 (n.º de apto./unidad/piso): | | | | | |  | Ciudad: |  | | |
| C.P.: | |  | Condado: | |  | | | | Estado: |  |

**Parentesco del cuidador con la persona que recibe cuidado:**

|  |  |  |  |
| --- | --- | --- | --- |
| Esposo | | Esposa | Pareja de hecho |
| Hijo/Yerno | | Hija/Nuera | Hermana |
| Hermano | | Abuelo/a | Padre/Madre |
| Otro familiar: |  | | |
| Otro no familiar: |  | | |

**Criterios de elegibilidad para los servicios para cuidadores**

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| --- | --- |
| **Cuidador familiar de un adulto mayor** | **Persona que recibe la atención** |
| Un familiar u otra persona (p. ej. un amigo o vecino) adulto (de 18 años de edad o más) que es un proveedor informal (es decir, sin sueldo) de atención en el hogar o en la comunidad para la persona que recibe la atención | Una persona mayor (de 60 años o más) *o*  Una persona (menor de 60 años) con la enfermedad de Alzheimer o un trastorno relacionado con disfunción cerebral neurológica y orgánica |

|  |  |
| --- | --- |
| **Cuidador familiar mayor/Abuelo(a) de un niño** | **Persona que recibe la atención** |
| Un abuelo, abuelastro u otro familiar mayor del niño por consanguinidad, matrimonio o adopción, que tenga al menos 55 años de edad y que viva con el niño, y que un acuerdo legal o informal lo identifique como el cuidador principal | Un niño (menor de 18 años) *o*  Una persona (de 18 a 59 años) con una discapacidad |

**Divulgaciones y Exenciones**

*Fui informado de las políticas relativas a los aportes voluntarios, los procedimientos para presentar quejas y los derechos de apelación. Soy consciente de que, para recibir los servicios solicitados, puede ser necesario compartir información con otros departamentos o proveedores de servicios y doy mi consentimiento para ello.*

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| --- | --- | --- | --- |
| **Firma:** |  | **Fecha:** |  |

***Para uso exclusivo de la oficina –***

*(Si lo completa un asesor o lo hace por teléfono, pídale que marque aquí y que firme a continuación)*  )

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| **Llenado por:** |  | **Fecha:** |  |

**DELETE THE FOLLOWING PAGES BEFORE PROVIDING THE FORM TO CLIENTS**

**Caregiver Counseling/Training/Support Groups Assessment Form Instructions**

**Services that must use the Caregiver Counseling/Training/Support Groups Assessment form for meeting minimum state and federal client registration and reporting requirements:**

* Caregiver Counseling, including Grandparent Caregiver Counseling
* Caregiver Support Groups, including Grandparent Caregiver Support Groups
* Caregiver Training (including Evidence Based Caregiver Programs), including Grandparent Caregiver Training
* Vouchers for all services that fall into the service categories above

For Title III E Caregiver Services, the Caregiver is the client. For every caregiver, there must be a link to a care recipient client record in SUDS. You can use the information provided about the Care Recipient in the Care Recipient Information section of this form to create a Care Recipient Client Record in SUDS. Care Recipients of Caregivers receiving Caregiver Counseling, Training, or Support Groups do not need an In-Home Assessment.

* Caregiver Services where registering clients and demographic data collection is optional - AAAs can also use this form for registering clients in services where registration is not required by state or federal reporting guidelines, including:
  + Caregiver Information and Assistance
  + Caregiver Information Services

**All clients filling in the Caregiver** **Counseling/Training/Support Groups Services Assessment Form should also be provided with:**

* Client Information/FAQs sheet
* Disclosures/Waivers sheet

**Caregiver / Care Recipient Relationship:**

Each Caregiver receiving registered OAA Title III-E Caregiver services needs to have a linked Care Recipient using the Caregiver Relationship to Care Recipient form in SUDS. The Caregiver’s Relationship to Care Recipient and OAA Caregiver Services Eligibility are required.

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

The Caregiver’s relationship to their care recipient(s) is required for federal reporting. This information must be entered into SUDS when creating the Caregiver/Care Recipient Relationship. The Older Americans Act reporting categories for Caregiver-Care Recipient Relationship:

* Husband
* Wife
* Domestic Partner, including civil union
* Son/Son-in-Law
* Daughter/Daughter-in-law
* Sister
* Brother
* Grandparent
* Parent
* Other Relative
* Non-Relative

**Caregiver Services Eligibility Criteria:**

* Family caregiver of an older individual (age 60+)
* Family caregiver of an individual (age < 60) with Alzheimer’s disease or related disorder
* Grandparent/Older Relative Caregiver (age 55+) of a child (age <18)
* Grandparent/Older Relative Caregiver (age 55+ of an individual (age 18-59) with a disability

**Care Recipient Information:**

Care Recipients must have a Client Record created for them in SUDS. They should be linked to their Caregiver when you create a Caregiver / Care Recipient Relationship.

**Demographic Questions:**

The following demographic information is required for federal reporting and the questions are required on all forms. Clients can choose to refuse to answer any of the questions, but they need to be given an informed choice about whether to provide their demographic information. This information must be entered into the SUDS Client record for all clients receiving services that require registration:

* DOB (to calculate age as of the end of the Federal Fiscal Year)
* Gender
* Zip code (to determine non-rural/rural geography)
* Ethnicity
* Race
* Lives With
* Poverty (income above or at/below poverty)

**Collecting Additional Client Information:**

* You can collect more client information on your region’s assessment forms than the minimum information required by the SUA Standard Assessment Forms.
* Check the Optional Assessment Questions and Alternative Wording documents for ideas on collecting more client information
* For SUDS Data Entry (if applicable), double check where to enter info & train staff/providers on data entry
* You can also add your own local questions that are not listed in the Optional Assessment Questions. If you would like to enter this information into SUDS, get in touch with the SUDS Help Desk for guidance.

**Waitlist and Targeting Considerations:**

* Some services that can use this form may require additional questions based on a region’s waitlist and targeting prioritization criteria.
* Waitlist and targeting prioritization may differ by region and service, and we do not include all possible prioritization questions on the Standard SUA Assessment Form.
* Please follow the directions above on Collecting Additional Client Information for adding Waitlist and Targeting Prioritization questions to your forms