Family Caregiver Assessment Form

Welcome! Please tell us a bit about yourself so we can offer services that best meet your needs. All your personal information is confidential. Please see the attached FAQs for more information.

# Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: Click or tap here to enter text.

Middle Name (if applicable): Click or tap here to enter text.

Last Name: Click or tap here to enter text.

Nickname (if applicable): Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Age: Click or tap here to enter text.

# Caregiver/Care Recipient Relationship

* Please check the box to confirm that you are an eligible Family Caregiver of an Older Adult:

You are an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (unpaid) provider of in-home or community care to the care recipient

* Please select the eligibility for your care recipient:

Your care recipient is an older individual (60 years of age or older) with 2+ ADL limitations;

or

Your care recipient is an individual with dementia or related neurological or cognitive disorder

* What is your relationship to the care recipient?

Husband

Wife

Domestic Partner

Son/Son-in-Law

Daughter/Daughter-in-law

Sister

Brother

Grandparent

Parent

Other Relative:Click or tap here to enter text.

Non-Relative:Click or tap here to enter text.

# Contact Information Section

Home Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Home Address Line 1: Click or tap here to enter text.

Home Address Line 2 (Apt/Unit/Floor): Click or tap here to enter text.

County: Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

Mailing address is the same as home address

Mailing Address Line 1: Click or tap here to enter text.

Mailing Address Line 2 (Apt/Unit/Floor): Click or tap here to enter text.

City: Click or tap here to enter text.

State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

# Demographics Section – Used for Anonymous Reporting to Our Funders

* Gender (select all that apply):

Male

Female

Non-binary/Third gender

Transgender

Another gender not listed: Click or tap here to enter text.

Refuse to answer question

* Ethnicity:

Hispanic or Latino/a/e

Not Hispanic or Latino/a/e

Refuse to answer question

* Racial Identity (select all that apply):

American Indian or Alaska Native

Asian or Asian American

Black or African American

Middle Eastern or North African

Native Hawaiian or Pacific Islander

White

Another identity not listed: Click or tap here to enter text.

Refuse to answer question

* Do you live alone or with others?

Alone

With others

Refuse to answer question

* Is your income above or at/below the amount listed for your household size in the table:

Above

At/below

Refuse to answer question

## Income Levels Table

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,304 | $15,650 |
| 2 | $1,763 | $21,150 |

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

# Communication Section

What is your primary language? Click or tap here to enter text.

# Service Access and Support Section

* Can you access this service through another benefit or program? For example, through your care recipient’s Medicaid, VA or Medicare benefits or food assistance programs

Yes

No

Refuse to answer question

I don’t know

* Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select “Yes” if any of the following statements are true for you:
  + You live in a remote area, or
  + You have a health condition or disability that makes it difficult for you to access community resources, or
  + You have financial or technology challenges that make it difficult for you to access community resources, or
  + You cannot drive or use public transportation, or
  + You do not feel welcome in your community due to cultural or language barriers

Yes

No

Refuse to answer question

# Emergency Contact Section

Name:Click or tap here to enter text.

Phone:Click or tap here to enter text.

Relationship:Click or tap here to enter text.

Refuse to provide contact

# Caregiver Needs Section

* Are you getting help from anyone with your caregiver duties?

Yes – professional/paid (formal) help

Yes – informal help

Yes – both formal and informal help

No

Refuse to answer question

* + If yes, please explain: Click or tap here to enter text.

# Modified Caregiver Strain Index

Here is a list of things that caregivers may find to be difficult. If an item applies to you, please indicate whether it applies on A Regular Basis or Sometimes. If an item does not apply to you, please mark No. Your situation may be slightly different, but the item could still apply.

1. My sleep is disturbed. For example: person I care for wanders at night; needs assistance; I can’t sleep

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. Caregiving is inconvenient. For example: helping takes a lot of time; it’s a long drive over to help

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. Caregiving is a physical strain. For example: lifting in or out of a chair/bed/toilet

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. Caregiving is confining. For example: restricts my free time; I cannot go places I enjoy

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. There have been family adjustments. For example: helping has disrupted my routine; there is no privacy; family arguments

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. There have been changes in personal plans. For example: I could not go on vacation; I cannot participate in activities that I enjoy

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. There have been other demands on my time. For example: other family members need me; work

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. There have been emotional adjustments. For example: arguments with family about caregiving; anger; sadness

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. Some behavior is upsetting. For example: person cared for has memory issues; outbursts

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. It is upsetting to find the person I care for has changed so much from their former self. For example: the care recipient is a different person than they used to be; unable to do things

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. There have been work adjustments. For example: I have to take time off for caregiving duties; adjusting schedules; unable to work

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. Caregiving is a financial strain. For example: I use personal finances for caregiving; unsure about future financial situation

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

1. I feel completely overwhelmed. For example: I worry about the person I care for; I have concerns for my future

Yes, on a regular basis, add 2 points to the score

Yes, sometimes, add 1 point to the score

No, add 0 to the score

Refuse to answer questions

Total Caregiver Strain Index Score:Click or tap here to enter text.

# Care Recipient Assessment Form

Please fill in this form about your care recipient

# Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: Click or tap here to enter text.

Middle Name (if applicable): Click or tap here to enter text.

Last Name: Click or tap here to enter text.

Nickname (if applicable): Click or tap here to enter text.

Date of Birth: Click or tap here to enter text.

Age: Click or tap here to enter text.

# Eligibility for the Care Recipient

* Cognitive Impairment Eligibility Screening: The care recipient has cognitive impairment; and, the care recipient needs another person to provide physical guidance or spoken instructions to keep the care recipient or others safe

Yes

No

* The care recipient has 2 or more activity of daily living limitations

Yes

No

# Contact Information Section

* Does the care recipient live with the caregiver?

Yes, if yes, skip to the Demographics Section

No

Home Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

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Home Address Line 2 (Apt/Unit/Floor): Click or tap here to enter text.

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State: Click or tap here to enter text.

Zip: Click or tap here to enter text.

# Demographics Section – Used for Anonymous Reporting to Our Funders

* Gender (select all that apply):

Male

Female

Non-binary/Third gender

Transgender

Another gender not listed: Click or tap here to enter text.

Refuse to answer question

* Ethnicity:

Hispanic or Latino/a/e

Not Hispanic or Latino/a/e

Refuse to answer question

* Racial Identity (select all that apply):

American Indian or Alaska Native

Asian or Asian American

Black or African American

Middle Eastern or North African

Native Hawaiian or Pacific Islander

White

Another identity not listed: Click or tap here to enter text.

Refuse to answer question

* Do you live alone or with others?

Alone

With others

Refuse to answer question

* Is your income above or at/below the amount listed for your household size in the table:

Above

At/below

Refuse to answer question

## Income Levels Table

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| --- | --- | --- |
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# Communication Section

What is your primary language? Click or tap here to enter text.

# Service Access and Support Section

* Health Insurance (select all that apply):

Medicare

Medicare Advantage

Medicaid

Medicaid Waiver(s)

VA

Private

None   
Other insurance: Click or tap here to enter text.

Refuse to answer question

* Are you homebound? Select “Yes” if any of the following statements are true for you:
  + You need the help of another person to leave your home, or
  + You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
  + You are only able to leave your home infrequently and for short periods of time

Yes

No

Refuse to answer question

* Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select “Yes” if any of the following statements are true for you:
  + You live in a remote area, or
  + You have a health condition or disability that makes it difficult for you to access community resources, or
  + You have financial or technology challenges that make it difficult for you to access community resources, or
  + You cannot drive or use public transportation, or
  + You do not feel welcome in your community due to cultural or language barriers

Yes

No

Refuse to answer question

# Emergency Contact Section

Name: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Relationship: Click or tap here to enter text.

Refuse to provide contact

# Nutrition Screening Section

## Nutrition Risk Score

Determine your nutritional health. If the statement is true for you, select the “Yes” checkbox and add the “Yes Score” points to your total score.

## Nutrition Risk Score Questions

1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you eat fewer than 2 meals per day?

Yes, if yes, add 3 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you eat few fruits, vegetables, or milk products?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you have 3 or more drinks of beer, liquor, or wine almost every day?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you have tooth or mouth problems that make it hard for you to eat?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Are there times you do not have enough money to buy the food you need?

Yes, if yes, add 4 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you eat alone most of the time?

Yes, if yes, add 1 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Do you take 3 or more different prescribed or over the counter drugs a day?

Yes, if yes, add 1 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Without wanting to, have you lost or gained 10 pounds in the last 6 months?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

1. Are there times you’re physically unable to shop, cook, and/or feed yourself?

Yes, if yes, add 2 to your total score

No, if no, add 0 to your total score

Refuse to answer question

Total Nutrition Risk Score (Total “Yes” Score): Click or tap here to enter text.

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

If you are at high nutrition risk – speak with a qualified health or social service professional.

# Activities of Daily Living – Must Be Completed for Eligibility

For each activity, please mark the level of help the care recipient needs.

1. Bathing or showering

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

1. Dressing - Putting on and taking off clothing and shoes

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

1. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

1. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

1. Walking/Getting Around the House

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

1. Eating and drinking

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Comments on ADLs: Click or tap here to enter text.

# Instrumental Activities of Daily Living

For each activity, please mark the level of help the care recipient needs.

1. Meal Preparation - Planning, making, and cleaning up meals

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Shopping - Selecting and paying for food, household supplies, clothing, and other items

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Medication Management - Getting prescriptions filled and taking medications as prescribed

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Money Management - Budgeting, using cards and bank accounts, paying bills

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Using a Telephone - Making and receiving calls

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Light Housework – Tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Heavy Housework – Deep cleaning the home, moving light furniture to clean under/behind

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

1. Transportation – Driving, walking, or using other forms of available transportation, like buses

Independent: I don’t need any help with this activity

Some help: I need some help or reminders from another person, but I can do parts of this activity on my own

Dependent: I always need help from another person to do this activity

Refuse to answer question

Comments on IADLs: Click or tap here to enter text.

* Does anyone help you with ADL or IADL activities?

Yes  
No

Refuse to answer question

* + If yes, who is assisting you? Click or tap here to enter text.
* Are you interested in learning about nutrition and a healthy diet? If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone’s camera to enroll or text the word FRUIT to 97699. Message & Data Rates May Apply. Text HELP for information. Text STOP to 97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit [Text 2 Live Healthy](https://coloradosph.cuanschutz.edu/text2livehealthy).



# 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 providers and I give my consent to do so.

Signature: Click or tap here to enter text.

Date: Click or tap here to enter text.

If filled out by someone other than the client (for example a caregiver or assessor, please check here  and sign below)

Filled out by: Click or tap here to enter text.

Date: Click or tap here to enter text.