**Caregiver Respite/Supplemental Services/Case Management Assessment**

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.

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| --- | --- | --- | --- | --- |
| **Caregiver Contact & Demographic Information:** | | | | |
| **First Name:** |  | **Middle Name:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** |  | **Nickname:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Birth:** | | | |  | | | | | | **Age:** |  | |
| **Home Address** Line 1: | | | | | |  | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | |  | | | | City: | |  | | |
| Zip: |  | | County: | | | |  | | | | | | State: |  |
| **Mailing Address** Line 1: | | | | | |  | | | | | | | | | | |
| Line 2 (Apt/Unit/Floor #): | | | | | |  | | | | City: | |  | | |
| Zip: |  | | County: | | | |  | | | | | | State: |  |

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| |  |  | | --- | --- | | **Mailing Address Same as Home Address:** |  |   **Home Location Comments** (additional directions for home or mailing address): |
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| --- | --- | --- | --- | --- |
| **Home Phone:** | |  | **Cell Phone:** |  |
| **Email:** |  | | | |

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| --- | --- | --- | --- | --- |
| **Gender:** | Male | Female | Non-Binary/Third Gender |  |

**Identify as:**  Transgender  Cisgender (identify with your gender from birth)

|  |  |  |  |
| --- | --- | --- | --- |
| Gender, if not listed: | |  | |
| **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino | | | | |
| **Race, select all that apply:** | | | | |
| American Indian or Alaska Native | | | | Middle Eastern or North African |
| Asian or Asian American | | | | Native Hawaiian or Pacific Islander |
| Black or African American | | | | White |
| Race, if not listed: | |  | | |

**Do you live:**  Alone  With Others

|  |  |
| --- | --- |
| **Number of people in your household** (including you): |  |

**Is your income above or below the amount listed for your household size:**

Above  At/Below

|  |  |  |
| --- | --- | --- |
| Household Size | Monthly Income | Annual Income |
| 1 | $1,255 | $15,060 |
| 2 | $1,703 | $20,440 |
| 3 | $2,152 | $25,820 |
| 4 | $2,600 | $31,200 |
| 5 | $3,048 | $36,580 |
| 6 | $3,497 | $41,960 |
| 7 | $3,945 | $47,340 |
| 8 | $4393 | $52,720 |
| For each additional person, add $5,380 to annual income | | |

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| **Communication & Service Needs:** |

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| --- | --- |
| **Primary language:**  English  Spanish  Other, if not listed: |  |

**Would you like to hear about other services?** Yes  No

**If yes, how can we contact you?**  Email  Mail  Phone

|  |  |
| --- | --- |
| **What services are you interested in?** |  |
|  | |

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| **Caregiver/Care Recipient Relationship Information:** |

*Please provide information for each individual care recipient you care for. If the care recipient is an adult (18+), please also complete an In-Home Assessment Form.*

**Care Recipient Information:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** |  | | **Last Name:** | | |  | |
| **Date of Birth:** | |  | | **Age:** |  | |

**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: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Husband | | Wife | Domestic Partner |
| Son/Son-in-Law | | Daughter/Daughter-in-law | Sister |
| Brother | | Grandparent | Parent |
| Other Relative: |  | | |
| Non-Relative: |  | | |

**Caregiver Services Eligibility:**

|  |  |
| --- | --- |
| **Family Caregiver of an Older Adult** | **Care Recipient** |
| 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 the Care Recipient | An older individual (60 years of age or older) *or*  An individual (age < 60) with Alzheimer’s disease or related disorder with neurological and organic brain dysfunction |

|  |  |
| --- | --- |
| **Older Relative Caregiver/Grandparent of a Child** | **Care Recipient** |
| A grandparent, step-grandparent, or other older relative of the child by blood, marriage, or adoption who is at least 55 years old living with the child, and identified as the primary caregiver through a legal or informal arrangement | A child (less than 18 years old)  *or*  An individual (18 to 59 years old) with a disability |

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| **Caregiver Assessment - Additional Questions:** |

**Which types of caregiver services are you interested in? Select all that apply:**

Information about services

Counseling

Education/Training

Support Groups

Meals (delivered to your home or dining at a community site)

Transportation

Supplies to assist with caregiving duties (e.g. food, assistive devices)

Respite Care (in-home or out-of-home supports/arrangements to provide caregivers temporary break from caregiving duties)

Adult Day Care programs for care recipients

Resources for grandparents raising grandchildren(ren)

|  |  |
| --- | --- |
| Other, if not listed: |  |
|  | |

**What type(s) of assistance do you provide to the care recipient? Select all that apply:**

|  |  |  |
| --- | --- | --- |
| Hygiene (bathing, grooming, etc.) | | Transportation |
| Dressing | | Errands/Shopping |
| Eating/Feeding | | Maintenance of home/yard |
| Meal preparation | | Housekeeping and laundry |
| Using the bathroom/incontinence | | Managing finances/paying bills |
| Getting around the home | | Administering medication |
| Getting in/out of beds and chairs | | Medical treatment/Managing condition(s) |
| Other, if not listed: |  | | |

**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

|  |  |
| --- | --- |
| **If yes, please explain:** |  |
|  | |

**What is your employment status?**

Retired  Employed full-time  Employed part-time  Unemployed  On Leave

|  |  |  |  |
| --- | --- | --- | --- |
| Other, if not listed: |  | | |
| Client Doesn’t Know | | Client Refused | Not Collected |

**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:** |  | **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:** |  |

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

**Caregiver Respite/Supplemental Services/Case Management Assessment Form Instructions**

**Services that must use the Caregiver Respite/Supplemental Services/Case Management Assessment Form for meeting minimum state and federal client registration and reporting requirements:**

Caregiver Supplemental Services (all types including material aid, home delivered meals, congregate meals, screening/evaluation, & transportation) including Grandparent Caregiver Supplemental Services

* Caregiver Case Management including Grandparent Caregiver Case Management
* Caregiver Respite including Grandparent Caregiver Respite
* Vouchers for all services that fall into the service categories above

Caregiver services requiring the Caregiver Counseling/Training/Support Groups Assessment Form can also use this form.

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.

**Adult Care Recipients of Caregivers receiving the Caregiver Services listed above need an In-Home Assessment.**

**All clients filling in the Caregiver Respite/Supplemental Services/Case Management 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