SECTION 1 – Service Information

Provider Name:	**Registration/Assessment Date:**
Region/Site Name:	***Termination Date:** ***Reason:**

Title III E, Family Caregiver Support Program Services To Be Provided

Support Services:
- ☐ Caregiver Assessment
- ☐ Caregiver Counseling
- ☐ Caregiver Peer Counseling
- ☐ Caregiver Support
- ☐ Caregiver Training
- ☐ Case Management

Respite Care Services: *(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/elder caregiver to qualify)*
- ☐ In-Home Supervision
- ☐ Homemaker Assistance
- ☐ In-Home Personal Care
- ☐ Home Chore
- ☐ Out of Home Day
- ☐ Out of Home Overnight

Supplemental Services: *(Care Receiver has to have 2 or more ADL limitations, a cognitive impairment, or be a grandparent/older caregiver to qualify)*
☐ Assistive Devices ☐ Home Adaptations for Caregiving ☐ Caregiving Services Registry ☐ Cash/Material Aid

Access Assistance:
- ☐ Information & Assistance
- ☐ Caregiver Outreach
- ☐ Interpretation/Translation
- ☐ Caregiver Legal Resources

Information Services:
- ☐ Public Information on Caregiving
- ☐ Community Education on Caregiving

SECTION 2 – Eligibility Criteria

Caregiver Caring for Elderly Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No
2. Is the Caregiver 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 an "elderly" Care Receiver? ☐ Yes ☐ No

If the Care Receiver does not meet any of the criteria above, the Caregiver is ineligible to receive FCSP Caregiver Caring for Elderly services, but may qualify to receive other services provided by the Area Agency on Aging.

Notes:

SECTION 3 (FCSP Caregiver)

(*) Required for Family Caregiver Support Program Services

Caregiver Personal Data (Please Print):	
***Unique Participant ID**	
First Name:	
Middle Initial:	
Last Name:	
***What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
***How do you describe your sexual orientation or sexual identity (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date**:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )

Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
***Ethnicity**:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
***Federal Poverty Level (FPL)**	☐ At or below FPL ☐ Above FPL ☐ Declined to State
***Lives Alone?**	☐ Yes ☐ No ☐ Declined to State
***Rural?**	☐ Yes ☐ No ☐ Declined to State

***Race: (** Please Check all that apply **)**

☐ White ☐ Black ☐ American Indian/Alaska Native
☐ Other Race ☐ Multiple Race

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

***Relationship to Care Receiver**	☐ Husband ☐ Wife ☐ Grandparent ☐ Domestic Partner ☐ Other Relative ☐ Daughter/Daughter- in-law ☐ Brother ☐ Sister ☐ Son/Son-in-law ☐ Non Relative ☐ Declined to State
***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State
***Employment:**	☐ Full Time ☐ Unemployed ☐ Part Time ☐ Declined to State ☐ Retired

SECTION 4 (Care Receiver)

(*) Required for Family Caregiver Support Program Services

***Unique Participant ID:**	
Care Receiver Personal Data (Please Print):	
First Name:	
Middle Initial:	
Last Name:	
*** What is your gender? (Check only one)**	☐ Male ☐ Female ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer/Gender Non-binary ☐ Not Listed, please specify: _____ ☐ Declined/not stated
*** What was your sex at birth? (Check only one)**	☐ Male ☐ Female ☐ Declined/not stated
*** How do you describe your sexual orientation or sexual identity (Check only one)**	☐ Straight/Heterosexual ☐ Bisexual ☐ Gay/Lesbian/Same-Gender Loving ☐ Questioning/Unsure ☐ Not Listed, please specify: _____ ☐ Declined/not stated
***Birth Date**:	
Last 4 Digits Social Security # *Optional*	☐☐☐☐
Home Phone #:	( )
Residential Address:	
Street:	
City:	
*Zip Code:	

Mailing Address: Same As Residential? ☐ Yes – Skip to Next Section	
Street:	
City:	
* Zip Code:	
***Ethnicity**:	☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State
***Federal Poverty Level (FPL)**	☐ Yes (At or below FPL) ☐ No (Above FPL) ☐ Declined to State
***Lives Alone?**	☐ Yes ☐ No ☐ Declined to State
***Rural?**	☐ Yes ☐ No ☐ Declined to State

***Race: (** Please Check all that apply **)**

☐ White ☐ Black
☐ American Indian/Alaska Native
☐ Other Race
☐ Multiple Race

Asian:

☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Vietnamese ☐ Other Asian

Hawaiian/Other Pacific Islander:

☐ Guamanian ☐ Hawaiian ☐ Samoan
☐ Other Pacific Islander
☐ Declined to State

***Relationship Status:**	☐ Single (never married) ☐ Married ☐ Domestic Partner ☐ Brother ☐ Sister ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

SECTION 5 (Care Receiver)

***ADLs & IADLs (Activities of Daily Living & Instrumental Activities of Daily Living)**

Required for Support Services, Respite Care, and Supplemental Services.

Please rate your functional abilities for the following activities.

ADLs	Rated Value	IADLs	Rated Value	IADLS	Rated Value	RATING SCALE
Feeding		Meal Preparation		Light Housework		1 = Independent
Dressing		Shopping		Heavy Housework		2 = Verbal Assistance
Bathing		Manage Medication		Notes:		3 = Some Human Help
Transferring In/Out of Chair		Money Management				4 = Lots of Human Help
Walking		Telephone				5 = Dependent
Toileting		Transportation				6= Declined to State