CAT 8-1-22

1. INTRODUCTION

1.A. CAREGIVER'S IDENTIFICATION

1. Date of the face to face interview for Caregiver Assessment Tool:

_____/_____/_____

2. Caregiver's Last Name:

_____

3. Caregiver's First Name:

_____

4. Caregiver's Date of Birth (DOB):

_____/_____/_____

5a. Caregiver's current gender identity (defined as one's inner sense of one's own gender) (Select one)

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Transgender Female (male to female)
- ☐ Transgender Male (female to male)
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Choose not to disclose

5b. Caregiver's sex assigned on their birth certificate at birth (Select one)

- ☐ Female
- ☐ Male
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Choose not to disclose

5c. Caregiver's sexual orientation (defined as one's identification of emotional, romantic, sexual, or affectional attraction to another person) (Select one)

- ☐ Bisexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Straight or Heterosexual
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Don't know
- ☐ Choose not to disclose

6. Caregiver's Ethnicity (Check only one):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

7. Caregiver's Race (Check all that apply):

- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Non-Minority (White, non-Hispanic)
- ☐ White-Hispanic
- ☐ Unknown/Unavailable
- ☐ Other - Document Details in Notes

8. Caregiver's Social Security Number (SSN):

_____-_____-_____

9. Is the Caregiver's household annual income less than 100% of the current Federal Poverty Income Guidelines (FPIG)?

- ☐ Yes
- ☐ No
- ☐ Unknown

1.B. ASSESSMENT INFORMATION

1. PSA number conducting assessment:

- ☐ 01
- ☐ 02
- ☐ 03
- ☐ 04
- ☐ 05
- ☐ 06
- ☐ 07
- ☐ 08
- ☐ 09
- ☐ 10
- ☐ 11
- ☐ 12
- ☐ 13
- ☐ 14
- ☐ 15
- ☐ 16
- ☐ 17
- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
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- ☐ 33
- ☐ 34
- ☐ 35
- ☐ 36
- ☐ 37
- ☐ 38
- ☐ 39
- ☐ 40
- ☐ 41
- ☐ 42
- ☐ 43
- ☐ 44
- ☐ 45
- ☐ 46
- ☐ 47
- ☐ 48
- ☐ 49
- ☐ 50
- ☐ 51
- ☐ 52

2. Indicate type of Caregiver Assessment:

- ☐ Initial Assessment
- ☐ Reassessment

3. Document the name and relationship of other individuals who participated in the assessment.

_____

_____

_____

_____

1.C. CAREGIVER'S DEMOGRAPHICS

1. Does the Caregiver require communication assistance?

- ☐ No. Skip to 1.C.3
- ☐ Yes

2. What type of communication assistance is required? (Document Details in Notes)

- ☐ Interpreter for a language other than English
- ☐ Sign language interpreter
- ☐ Other

3. What is the Caregiver's PRIMARY language?

- ☐ English
- ☐ Russian
- ☐ Spanish
- ☐ Other - Document Details in Notes

4. What is the Caregiver's employment status?

- ☐ Full-Time
- ☐ Part-Time
- ☐ Retired, but Works Part-Time
- ☐ Fully Retired
- ☐ Unemployed
- ☐ Other - Document Details in Notes

5a. Is the individual a Veteran?

- ☐ No
- ☐ Yes
- ☐ Unable to determine

5b. Is the individual the spouse/ widow or dependent child of a Veteran?

- [ ] No
- [ ] Yes
- [ ] Unable to determine

5c. Is the individual receiving Veteran's benefits?

- [ ] No
- [ ] Yes
- [ ] Unable to determine

6. What is the relationship of the Caregiver to the Care Receiver?

- [ ] Brother
- [ ] Domestic Partner, including civil union
- [ ] Daughter/ Daughter-in-law
- [ ] Grandparent
- [ ] Husband
- [ ] Parent
- [ ] Sister
- [ ] Son/ Son-in-law
- [ ] Step-Grandparent
- [ ] Wife
- [ ] Other Older Relative - Document relationship in Notes
- [ ] Other Non-Relative - Document relationship in Notes
- [ ] Other Relative - Document relationship in Notes
- [ ] Other - Document Details in Notes

1.D. CAREGIVER'S RESIDENTIAL ADDRESS INFORMATION

1. Is the Caregiver's postal/ mailing address exactly the same as the residential address?

- [ ] No - Complete Section 1.D. and 1.E.
- [ ] Yes - Complete only Section 1.D.

2a. Residential County

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York
- [ ] Out of State

2b. Residential Street Address:

_____

2c. Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.):

_____

2d. Residential Municipality - REQUIRED (Usually a Township or Boro where Caregiver Votes, Pays Taxes)

_____

2e. Residential City/ Town:

_____

2f. Residential State (2 character limit):

_____

2g. Residential Zip Code:

_____

3a. Primary Phone Number:

_____

3b. Mobile Phone Number:

3c. Other Phone Number (Enter additional number where Caregiver can be reached if applicable.):

3d. E-mail Address:

4. What was the outcome when the Caregiver was offered a voter registration form? REQUIRED

- ☐ AAA will submit completed voter registration
- ☐ Does not meet voter requirements (ie. Citizenship, etc.)
- ☐ Caregiver declined application
- ☐ Caregiver declined-already registered
- ☐ Caregiver will submit completed voter registration
- ☐ No Response

1.E. CAREGIVER'S POSTAL/ MAILING ADDRESS INFORMATION

1a. Postal Street Address:

1b. Postal Address Line 2 (optional):

1c. Postal City/ Town:

1d. Postal State (2 character limit):

1e. Postal Zip Code:

1.F. CAREGIVER'S EMERGENCY CONTACT

1. Name of Emergency Contact:

2. Relationship of Emergency Contact:

3. Telephone Number of Emergency Contact:

4. Work Telephone Number of Emergency Contact:

2. CAREGIVER EXPENDITURES

2.A. REPORTED EXPENDITURES OF CAREGIVER

1a. Do you currently pay for services to provide care to the Care Receiver?

- [ ] No
- [ ] Yes

1b. Document the type of service and estimated monthly cost.

_____

_____

_____

_____

2a. Do you currently pay for supplies that directly relate to providing care to the Care Receiver?

- [ ] No
- [ ] Yes

2b. Document the supplies purchased and estimated monthly cost.

_____

_____

_____

_____

3. Do you feel that you may need to purchase any Assistive Devices/ Technology which directly relates to providing care to the Care Receiver?

- [ ] No
- [ ] Yes - Document Details in Notes

4. Do you feel that you may need to purchase any Home Modifications which directly relate to providing care to the Care Receiver?

- [ ] No
- [ ] Yes - Document Details in Notes

3. CARE RECEIVER'S INFORMATION

3.A. CARE RECEIVER'S IDENTITY (Must not have an adult and a child CR on the same CAT)

1a. Care Receiver's Last Name (Adult or Child):

_____

1b. Care Receiver's First Name (Adult or Child):

_____

1c. Care Receiver's Date of Birth (DOB) (Adult or Child):

_____/_____/_____

1d. What is the Care Receiver's current gender identity (defined as one's inner sense of one's own gender)?

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Transgender Female (male to female)
- ☐ Transgender Male (female to male)
- ☐ Something else that was not named. Please specify (Document Details in Notes)
- ☐ Choose not to disclose

1e. Does the Care Receiver have a disability as defined by the Americans with Disabilities Act of 1990?

- ☐ Yes
- ☐ No
- ☐ Unknown

1f. What is the legal status of the CG/CR relationship? (Adult or Child)

- ☐ None
- ☐ Guardianship
- ☐ Legal Custody
- ☐ Physical Custody
- ☐ POA
- ☐ Other - Document Details in Notes
- ☐ Unknown

1g. Is the Care Receiver's address the same as the Caregiver's address?

- ☐ Yes. Skip to 3.B.1a
- ☐ No

1h. Care Receiver's Postal Street Address:

_____

1i. Care Receiver's Postal Address Line 2 (optional):

_____

1j. Care Receiver's Postal City/Town:

_____

1k. Care Receiver's Postal State (2 character limit):

_____

1l. Care Receiver's Postal Zip Code:

_____

1m. Care Receiver's County:

- [ ] Adams
- [ ] Allegheny
- [ ] Armstrong
- [ ] Beaver
- [ ] Bedford
- [ ] Berks
- [ ] Blair
- [ ] Bradford
- [ ] Bucks
- [ ] Butler
- [ ] Cambria
- [ ] Cameron
- [ ] Carbon
- [ ] Centre
- [ ] Chester
- [ ] Clarion
- [ ] Clearfield
- [ ] Clinton
- [ ] Columbia
- [ ] Crawford
- [ ] Cumberland
- [ ] Dauphin
- [ ] Delaware
- [ ] Elk
- [ ] Erie
- [ ] Fayette
- [ ] Forest
- [ ] Franklin
- [ ] Fulton
- [ ] Greene
- [ ] Huntingdon
- [ ] Indiana
- [ ] Jefferson
- [ ] Juniata
- [ ] Lackawanna
- [ ] Lancaster
- [ ] Lawrence
- [ ] Lebanon
- [ ] Lehigh
- [ ] Luzerne
- [ ] Lycoming
- [ ] McKean
- [ ] Mercer
- [ ] Mifflin
- [ ] Monroe
- [ ] Montgomery
- [ ] Montour
- [ ] Northampton
- [ ] Northumberland
- [ ] Perry
- [ ] Philadelphia
- [ ] Pike
- [ ] Potter
- [ ] Schuylkill
- [ ] Snyder
- [ ] Somerset
- [ ] Sullivan
- [ ] Susquehanna
- [ ] Tioga
- [ ] Union
- [ ] Venango
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westmoreland
- [ ] Wyoming
- [ ] York

3.B. CARE RECEIVER'S IDENTITY(S) when Multiple Child Care Receivers for Grandparent/Older Relative CSP.

1a. Child Care Receiver #2 Last Name:

_____

1b. Child Care Receiver #2 First Name:

_____

1c. Child Care Receiver #2 Date of Birth (DOB):

_____/_____/_____

1d. What is the current gender identity for Care Receiver #2 (defined as one's inner sense of one's own gender)?

- [ ] Female
- [ ] Male
- [ ] Non-Binary
- [ ] Transgender Female (male to female)
- [ ] Transgender Male (female to male)
- [ ] Something else that was not named. Please specify (Document Details in Notes)
- [ ] Choose not to disclose

1e. What is the legal status of the #2 Child CG/CR relationship?

- [ ] None
- [ ] Guardianship
- [ ] Legal Custody
- [ ] Physical Custody
- [ ] POA
- [ ] Other - Document Details in Notes
- [ ] Unknown

2a. Child Care Receiver #3 Last Name:

_____

2b. Child Care Receiver #3 First Name:

_____

2c. Child Care Receiver #3 Date of Birth (DOB):

_____/_____/_____

2d. What is the current gender identity for Care Receiver #3 (defined as one's inner sense of one's own gender)?

- [ ] Female
- [ ] Male
- [ ] Non-Binary
- [ ] Transgender Female (male to female)
- [ ] Transgender Male (female to male)
- [ ] Something else that was not named. Please specify (Document Details in Notes)
- [ ] Choose not to disclose

2e. What is the legal status of the #3 Child CG/CR relationship?

- [ ] None
- [ ] Guardianship
- [ ] Legal Custody
- [ ] Physical Custody
- [ ] POA
- [ ] Other - Document Details in Notes
- [ ] Unknown

3. Additional Child Care Receiver(s) information or notes:

_____

_____

_____

_____

3.C. CARE RECEIVER'S HOUSEHOLD COMPOSITION

1. What is the Care Receiver's PERMANENT living arrangement?

- [ ] Lives Alone
- [ ] Lives with spouse only
- [ ] Lives with child(ren) but not spouse
- [ ] Lives with other family member(s)
- [ ] Lives with primary Caregiver
- [ ] Other - Document Details in Notes

2. Document the name, age and relationship of each individual who resides in the Care Receiver's household.

_____

_____

_____

_____

3. What is the total number of individuals that reside in the Care Receiver's household?

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] Other - Document Details in Notes

4. CARE RECEIVER'S HOUSEHOLD FINANCIAL DATA

4.A. CARE RECEIVER'S INCOME

1. Refused to provide financial information?

- ☐ No
- ☐ Yes - Not Eligible for CSP, Skip to 8.C.1

2. Care Receiver's monthly Social Security Income (SS):

$

3. Care Receiver's monthly Supplemental Social Security Income (SSI):

$

4. Care Receiver's monthly retirement/ pension income:

$

5. Care Receiver's monthly interest/ dividends income:

$

6. Care Receiver's monthly public assistance:

$

7. Care Receiver's monthly VA benefit income:

$

8. Care Receiver's monthly wage/ salary/ earnings income:

$

9. Care Receiver's monthly net rental income:

$

10. Care Receiver's monthly railroad retirement benefit income:

$

11. Care Receiver's monthly annuity, trust, estate income:

$

12. Care Receiver's other monthly income (Document the source of income in Notes)

$

13. Care Receiver's Monthly Medicare Part B Premium:

$

14. Care Receiver Total Monthly Reportable Income

4.B. OTHER HOUSEHOLD MEMBER'S INCOME (Residing with Care Receiver *see Chapter for inclusions/exclusions)

1. Monthly Social Security (SS) income of other household member(s):

$

2. Monthly SSI of other household member(s):

$

3. Monthly retirement/ pension income of other household member(s):

$

4. Monthly interest/ dividend income of other household member(s):

$

5. Monthly public assistance income of other household member(s):

$

6. Monthly VA Benefits income of other household member(s):

$

7. Monthly wage/ salary/ earnings income of other household member(s):

$

8. Monthly NON-residential net rental income of other household member(s):

$

9. Other monthly income of other household member(s):

$

10. Monthly Medicare Part B Premium of other household member(s):

$

11. Other Household Members Total Monthly Income

4.C. HOUSEHOLD INCOME

1. Care Receiver Total Monthly Household Income

2. Total Care Receiver Household Annual Income

3. Percentage of Total Monthly Expenses AAA Reimburses Caregiver (If the total number of individuals residing in the Care Receiver's household is larger than 6 (if Q3.C.3 is "Other"), then the Reimbursement Percentage must be calculated manually)

4. Enter Percentage of Total Monthly Expenses AAA Reimburses Caregiver from 4.C.3 above.

5. Percentage of Total Monthly Expenses AAA Does Not Reimburse the Caregiver

6. Based on the calculated reimbursement percentage, does the Caregiver wish to continue with the assessment for the Caregiver Support Program?

- ☐ No - Document Details in Notes
- ☐ Yes

5. CAREGIVER'S SUPPORTS/ GENERAL ROLES AND RESPONSIBILITIES

5.A. FORMAL AND INFORMAL SUPPORTS

1. Check all benefits the Caregiver is currently receiving.

- [ ] None
- [ ] LIHEAP
- [ ] Food Stamps
- [ ] Medicaid
- [ ] PACE
- [ ] Section 8
- [ ] Subsidized Transit
- [ ] Tax and Rent Rebates
- [ ] Weatherization
- [ ] Other - Document Details in Notes
- [ ] Additional Services Needed - Document Details in Notes

2. Are there any additional INFORMAL supports that provide assistance or care to the Care Receiver? (Document name(s) and assistance/ care provided in Notes)

- [ ] None
- [ ] Friend/ Neighbor
- [ ] Community Supports (church, social organizations, etc.)
- [ ] Child/ Child-in-Law
- [ ] Spouse
- [ ] Other - Document Details in Notes

3. Is the Care Receiver receiving care or services from any FORMAL supports? (Document name(s) and care provided in Notes)

- [ ] None
- [ ] AAA Services
- [ ] Children & Youth
- [ ] Adult Day Care
- [ ] Counselor/Therapist
- [ ] Home Health Services
- [ ] Hospice
- [ ] School
- [ ] Therapeutic Staff Support (TSS)
- [ ] Other - Document Details in Notes

5.B. CAREGIVER'S GENERAL RESPONSIBILITIES

1. How long have you been providing the majority of assistance to the Care Receiver?

- [ ] Under 1 Year
- [ ] 1-2 Years
- [ ] 3-5 Years
- [ ] 5+ Years - Document Details in Notes

2. Tell me how you became responsible for the child(ren) in your care. (Grandparent/Older Relative Caregiver Program only)

_____

_____

_____

_____

3a. Does the care receiver have any mental health diagnoses which require monitoring or on-going services?

- [ ] No
- [ ] Yes - Document Details in Notes
- [ ] Don't Know

3b. Does the Care Receiver have any physical health diagnoses which require monitoring or on-going services?

- [ ] No
- [ ] Yes - Document Details in Notes
- [ ] Don't Know

4a. Does the Care Receiver have a diagnosis of Alzheimer's disease or dementia?

- [ ] No. Skip to 5.B.5.
- [ ] Yes. (If CR is age 18-59, obtain required documentation.)

4b. Does the Care Receiver require on-going services or supervision due to Alzheimer's disease or dementia? (Document details in Notes)

- [ ] No
- [ ] Yes

5. Does the care receiver exhibit behaviors that require monitoring? (Document Details in Notes)

- [ ] None
- [ ] Outbursts
- [ ] Physical harm toward self
- [ ] Physical harm toward others
- [ ] Wandering
- [ ] Other

6a. Are you able to leave the Care Receiver alone for any period of time?

- [ ] No. Skip to 5.B.7
- [ ] Yes

6b. How long can the Care Receiver safely be left alone?

- [ ] Indefinitely
- [ ] 24 hours
- [ ] A few hours - daytime only
- [ ] A few hours - night only
- [ ] All day
- [ ] All night

7. Do you assist in managing medical appointments for the Care Receiver? (Document Details in Notes)

- [ ] No
- [ ] Yes

8. Do you assist in managing the Care Receiver's medication(s)? (Document Details in Notes)

- [ ] No
- [ ] Yes

9. Do you assist in managing other special medical treatments for the Care Receiver? (Document Details in Notes)

- [ ] No
- [ ] Yes

6. CAREGIVER'S ASSISTANCE

6.A. ADL ASSISTANCE (Check all that apply)

1. Identify the assistance the CG provides the CR for BATHING:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

2. Identify the assistance the CG provides the CR for DRESSING:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

3. Identify the assistance the CG provides the CR for GROOMING:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

4. Identify the assistance the CG provides the CR for EATING:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

5. Identify the assistance the CG provides the CR for TRANSFERS:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

6. Identify the assistance the CG provides the CR for TOILETING:

- ☐ None
- ☐ Cueing /Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

7. Identify the assistance the CG provides the CR for BLADDER CARE:

- ☐ None
- ☐ Cueing/Coaxing
- ☐ Set-up
- ☐ Supervision
- ☐ Hands-on-Assistance
- ☐ Total Care
- ☐ Arranges Informal Supports
- ☐ Arranges Formal Supports
- ☐ Other
- ☐ Extra Help Needed

8. Identify the assistance the CG provides the CR for BOWEL CARE:

- [ ] None
- [ ] Cueing/Coaxing
- [ ] Set-up
- [ ] Supervision
- [ ] Hands-on-Assistance
- [ ] Total Care
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports
- [ ] Other
- [ ] Extra Help Needed

6.B. MOBILITY ASSISTANCE (Check all that apply)

1. Identify the assistance the CG provides the CR with INDOOR MOBIITY:

- [ ] None
- [ ] Cueing /Coaxing
- [ ] Set-up
- [ ] Supervision
- [ ] Hands-on-Assistance
- [ ] Total Care
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports
- [ ] Other

2. Identify the assistance the CG provides the CR with OUTDOOR MOBILITY:

- [ ] None
- [ ] Cueing /Coaxing
- [ ] Set-up
- [ ] Supervision
- [ ] Hands-on-Assistance
- [ ] Total Care
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports
- [ ] Other

3. Identify the assistance the CG provides the CR with STAIR MOBILITY:

- [ ] None
- [ ] Cueing /Coaxing
- [ ] Set-up
- [ ] Supervision
- [ ] Hands-on-Assistance
- [ ] Total Care
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports
- [ ] Other

6.C. IADL ASSISTANCE (Check all that apply)

1. Identify the assistance the CG provides the CR for MEAL PREP:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

2. Identify the assistance the CG provides the CR for HOUSEWORK:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Assistance
- [ ] Arranges Formal Supports

3. Identify the assistance the CG provides the CR for LAUNDRY:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

4. Identify the assistance the CG provides the CR for SHOPPING:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

5. Identify the assistance the CG provides the CR for TRANSPORTATION:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

6. Identify the assistance the CG provides the CR for MONEY MANAGEMENT:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

7. Identify the assistance the CG provides the CR for TELEPHONE:

- [ ] None
- [ ] Setup / Supervision
- [ ] Care receiver does not use the telephone

8. Identify the assistance the CG provides the CR for HOME MANAGEMENT:

- [ ] None
- [ ] Caregiver Provides
- [ ] Arranges Informal Supports
- [ ] Arranges Formal Supports

7. CAREGIVER'S WELL-BEING

7.A. CAREGIVER'S WELL-BEING

1. Do you find it difficult to provide care?

- ☐ No
- ☐ Yes - Document Details in Notes

2. On a scale of 1 to 5, are you concerned with your ability to provide care? (Document Details in Notes)

- ☐ 1 - Not Concerned
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 - Very Concerned

3. Are you experiencing any of the following challenges in your caregiving role? If yes, check all that apply. (Document details for each challenge in Notes)

- ☐ None
- ☐ Accessing services for the care recipient
- ☐ Affecting ability to complete personal tasks
- ☐ Additional help/respite is not available
- ☐ Affecting ability to participate in leisure activities
- ☐ Affecting sleep
- ☐ Affecting work attendance/ performance
- ☐ Creating challenges in relationships with others
- ☐ Emotional challenges
- ☐ Financial challenges
- ☐ Legal Challenges
- ☐ Life event that has impacted ability to provide care.
- ☐ Physical limitations/ medical issues impact ability to provide care
- ☐ Provides care to another adult or child(ren)
- ☐ Other - Document Details in Notes

4. How would you rate the quality of your relationship with the care receiver?

- ☐ Excellent-no issues
- ☐ Good-minimal issues/frustration, able to work through differences with CR
- ☐ Fair-occasional frustration/conflict with CR that requires occasional assistance
- ☐ Poor–frequent conflicts, unable to work through differences without intervention

5. Has your own health been affected in the last six months because of caregiving? (If Yes, please explain in the notes)

- ☐ No - Same
- ☐ Yes - Better
- ☐ Yes - Worse

6. On a scale of 1-5, how much stress are you experiencing due to your caregiving role?

- ☐ 1 - No Stress
- ☐ 2 - Minimal
- ☐ 3 - Moderate
- ☐ 4 - Significant
- ☐ 5 - Overwhelming

7. Do you want to continue to provide care for the care receiver?

- ☐ No - Document Details in Notes
- ☐ Yes

8. Do you feel as if you need additional information, training or education to provide care more effectively or to be more knowledgeable in specific areas?

- ☐ No
- ☐ Yes - Document Details in Notes

9. Has your role as a caregiver made positive contributions to your life in any of the following ways? (Document Details in Notes)

- ☐ No
- ☐ Feels more useful
- ☐ Feels needed
- ☐ Finding more meaning in life
- ☐ Has learned more about the Care Receiver's condition(s)
- ☐ Has improved relationship with care receiver
- ☐ Has learned skills to provide care
- ☐ Has successfully dealt with challenges related to caregiving
- ☐ Other - Document Details in Notes

10. Are there any activities that you participate in to maintain or improve your own quality of life?

_____

_____

_____

_____

11. What do you do to cope with being a caregiver?

_____

_____

_____

_____

12. What are you doing well as a caregiver?

_____

_____

_____

_____

8. CAREMANAGER OBSERVATIONS AND ASSESSMENT OUTCOME - DO NOT QUESTION CAREGIVER!

8.A. CARE MANAGER'S OBSERVATIONS

1. What conditions of the caregiving environment cause health and safety risks to the Caregiver and Care Receiver? (Document Details in Notes)

- [ ] None
- [ ] Appliances
- [ ] Clutter
- [ ] Cooling system
- [ ] Environmental pests
- [ ] Furnishings
- [ ] Hallways
- [ ] Heating system
- [ ] Lack of electricity
- [ ] Lack of refrigeration
- [ ] Lack of fire safety devices
- [ ] Lack of toilet
- [ ] Lack of water
- [ ] Lighting
- [ ] Pets
- [ ] Poor flooring
- [ ] Shower
- [ ] Stairs
- [ ] Structural issues
- [ ] Other - Document Details in Notes

2. What areas of the caregiving environment impact accessibility? (Document Details in Notes)

- [ ] None
- [ ] Bathroom
- [ ] Bedroom
- [ ] Home entryways
- [ ] Hallways
- [ ] Kitchen
- [ ] Laundry
- [ ] Stairs
- [ ] Other - Document Details in Notes

3. Care Manager's observations or concerns about the Caregiver. (Document Details in Notes)

- [ ] None
- [ ] Cognitive Issues
- [ ] Poor physical health, disabled, frail
- [ ] Possible mental health issues
- [ ] Possible alcohol/ drug abuse
- [ ] Unwilling to provide care
- [ ] Family or other responsibilities
- [ ] Poor relationship/ communication
- [ ] Other - Document Details in Notes

4. Based on the information provided, is the Caregiver able to provide and/or coordinate the care and services necessary to maintain the Care Receiver in the community?

- [ ] No - Document Details in Notes
- [ ] Yes

8.B. ASSESSMENT SUMMARY

1. Does the assessed Caregiver meet the definition of Primary Caregiver? (see Chapter VI)

- [ ] No - Document Details in Notes
- [ ] Yes

8.C. ASSESSMENT OUTCOME

1. Based on this assessment, is the Caregiver Support Program the appropriate program to provide support within this caregiving relationship?

- [ ] No - Document Details in Notes.
- [ ] Yes

2. Caregiver Assessment Score:

3. Caregiver Assessment Score - Enter the value from the previous question:

4. Care Manager believes the Care Receiver should be referred to other Aging Services Programs

- [ ] No
- [ ] Yes

8.D. ASSESSMENT OUTCOME AUTHENTICATION

1. Name of the Care Manager completing this assessment:

_____

2. Date (MM/DD/YYYY) of Care Manager signature:

_____/_____/_____

3. Name of Supervisor who reviewed and approved this assessment:

_____

4. Date (MM/DD/YYYY) Supervisor reviewed and approved this assessment:

_____/_____/_____

Title :

Date

Title :

Date