|  |  |
| --- | --- |
| **dhsslogo** | **Caregiver Assessment****Form CF-045** |

|  |  |
| --- | --- |
| Date of Assessment:       | Agency Name:       |
| Name of Care Recipient:       | Person Reporting:       |

|  |
| --- |
| Program: [ ]  Case Management [ ]  Respite [ ]  CRC [ ]  Other |

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name:       | First Name:       | [ ] Male | [ ] Female |
| Address:       | Apt #:       | County: [ ]  NCC [ ]  Kent [ ]  Sussex |
| Address 2 (Apt. Complex Name or Development Name):       |
| City:       | State:       | Zip:       | Rural: [ ]  Yes [ ]  No |
| Telephone 1:       | Telephone 2:       |  |

|  |
| --- |
| Caregiver’s Ethnicity: [ ]  Hispanic or Latino [ ]  NOT Hispanic or Latino |
|  Race: | [ ]  White – Non Hispanic |
| [ ]  White – Hispanic  |
| [ ]  American Indian/Alaska Native |
| [ ]  Asian |
| [ ]  Black or African American |
| [ ]  Native Hawaiian or Other Pacific Islander |
| [ ]  Other Race |
| Reporting 2 or More Races: [ ]  YES |
| Race Data Missing: [ ]  YES |

|  |
| --- |
| Caregiver’s Date of Birth (DOB):\*\*Required for Reporting\*\*[ ]  Not Reported |
| If DOB is unable to be collected, please check appropriate date range:[ ]  <50 [ ]  55-59 [ ]  75-84[ ]  50-54 [ ]  60-74 [ ]  85+ |
| Caregiver’s Relationship to Care Recipient:[ ]  Husband [ ]  Wife[ ]  Son/Son-in-Law[ ]  Daughter/Daughter-in-Law[ ]  Other Relative[ ]  Non-Relative[ ]  Relationship Not Reported |

|  |  |  |
| --- | --- | --- |
| Are you the PRINCIPAL CAREGIVER?  | [ ]  Yes | [ ]  No |
| Does the care recipient live with you? | [ ]  Yes | [ ]  No |
| Do you also care for children under 18 living at home? | [ ]  Yes | [ ]  No |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your employment status? | [ ]  Employed Full-Time | [ ]  Employed Part-Time | [ ]  Not Employed |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| On average, how many weekly hours of care do your provide? | [ ]  Less than 10 | [ ]  11 -20 | [ ]  21 - 30 | [ ]  30+ |

*Updated 10/11/2017*

|  |  |  |
| --- | --- | --- |
| Identify support services recommended to this Caregiver: | [ ]  Caregiver Skills Training[ ]  Adult Day Care[ ]  In-Home Respite[ ]  ERS Services[ ]  Counseling[ ]  Legal Assistance | [ ]  Home Modification[ ]  Assistive Technology[ ]  Support Group[ ]  Caregiver Resource Center[ ]  Transportation[ ]  Other:       |

|  |
| --- |
| Caregiver was given the following information/publications: |
| [ ]  ADRC Brochure | [ ]  CRC Flyer/Brochure | [ ]  DSAAPD Guide to Services |
| [ ]  Other:       |

|  |
| --- |
| Notes: Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Caregiver’s Suggested Donation Amount: | $       | Per: [ ]  Week [ ]  Month  |