**For Office Use Only Total Score**

**NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM**

**INTAKE ASSESSMENT FORM**

|  |
| --- |
| **SECTION A: AGENCY/ORGANIZATION INFORMATION** |
| **Date of Request or Referral:**   Month/Day/Year**Assessor Name:**   | **Method of Contact:** **[ ]** Telephone **[ ]** Face-to-Face **[ ]** Other **Agency Name:**   |
| **SECTION B: INITIAL SCREENING AND INTAKE** |
| **PERSON PROVIDING ANSWERS AND INFORMATION FOR ASSESSMENT:****[ ]** Caregiver **[ ]** Friend/Neighbor **[ ]** Legal Guardian or Surrogate Decision Maker**[ ]** Family Member **[ ]** Other Professional (e.g. Care Manager) |
| **PRIMARY LANGUAGE:****[ ]** English [ ]  Spanish [ ]  French **[ ]** Other  |
| **QUALIFYING INDIVIDUAL** (Person receiving care):**Name:** **Address:** **Apt #:** **City:** **State:**  **Zip Code:**  **Parish:** **Phone:** (cell / home)**Social Security Number:** **Date of Birth:** **Caregiver by relationship:** **[ ]** Husband **[ ]** Wife **[ ]** Son/Son-in-Law **[ ]** Daughter/Daughter-in-Law **[ ]** Other Relative **[ ]** Non-Relative |
| **SECTION C: CAREGIVER INFORMATION** |
| **Social Security Number:** **[ ]  [ ]  [ ] -[ ]  [ ]  [ ] -[ ]  [ ]  [ ]  [ ]** **Louisiana Identification Number: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]** **Last Name:** **First Name:** **MI:**  **Address:** **Apt #:** **City:** **State:**  **Zip Code:**  **Parish:** **Home Phone:** **Cell Phone:** **Date of Birth:** **Rural/Isolated:** **[ ]** Yes **[ ]** No**Gender (at-birth):** **[ ]** Male **[ ]** Female **Gender Identity : [ ]** Other: \_\_\_Male \_\_\_Female \_\_\_Transgender-Male \_\_\_ Transgender-Female \_\_\_Non-Disclosed \_\_\_Non-Binary **Race:** **[ ]** White (Alone) **Marital Status:** **[ ]** Never Married **[ ]** Black or African American (Alone) **[ ]** Married **[ ]** American Indian/Alaskan Native (Alone) **[ ]** Partner/Significant Other **[ ]** Native Hawaiian/Other Pacific Islander **[ ]** Widowed **[ ]** Asian (Alone) **[ ]** Separated **[ ]** Declined to Respond **[ ]** Divorced **[ ]** Other **Ethnicity:** **[ ]** Hispanic/Latino **[ ]** Not Hispanic/Latino |
|  |

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**INTAKE ASSESSMENT FORM**

**Name of Client (Caregiver):** **ID #:**

|  |
| --- |
| **SECTION D: PRIORITY STATUS (Check all that apply)** |
|  **[ ]** Client is an older individual in greatest economic need **[ ]** Client is an older individual in greatest social need **[ ]** Client is an older individual providing care and support to person who has a developmental disability |
| **Eligibility for Respite Care, Personal Care, Material Aid and Sitter Service**(Check all that apply – at least one must apply to be Eligible): |
|  **[ ]** The Qualifying Individual is unable to perform at least two of the following activities without substantial  human assistance, including verbal reminding, physical cueing, or supervision: **[ ]** Dressing **[ ]** Toileting **[ ]** Transferring **[ ]** Walking **[ ]** Eating **[ ]** The Qualifying Individual **has a cognitive or other mental impairment** and requires substantial supervision because the individual behaves in a manor that poses a serious health or safety hazard to the individual or to another individual.**[ ]** The Qualifying Individual is/will be on “Hospice”. |
| **Describe the type of assistance needed (continue on supplemental sheet/s):** |
|       |
| **Directions to the Home of Qualifying Individual (continue on supplemental sheet/s):** |
|       |
| **I have received a copy of the Grievance Procedure and Contributions Policy.****Signature of Caregiver:**  **Date:** **Signature of Intake Worker:** **Date:**  |

**NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM**

**INTAKE ASSESSMENT FORM**

**Name of Client (Caregiver):** **ID #:**

|  |  |
| --- | --- |
| 1. The Caregiver’s income level is at or below the Federal Poverty line. **No = 0 Yes = 1**
 |  |
| 1. The Caregiver has “greatest social need”.  **No = 0 Yes = 1**
 |  |
| 1. The Caregiver is 60 years of age or older and providing care and support to person that has a developmental disability. **No = 0 Yes = 1**
 |  |
| 1. Age of Caregiver: **Under 60 = 0 60-74 years of age = 1 75 years of age or older = 2**
 |  |
| 1. How does the Caregiver rate his/her overall health? **Good = 0 Fair = 1 Poor = 2**
 |  |
| 1. For how many qualifying individuals is this Caregiver the primary Caregiver? (1 point for each qualifying individual)
 |  |
| 1. How many hours of direct care on average each day does the Caregiver provide to the qualifying individual? **8 hours or less = 0 9-16 hours = 1 17-24 hours = 2**
 |  |
| 1. Is the Caregiver employed? **No = 0 Part-time = 1 Full-time (35 or more hours a week) = 2**
 |  |
| 1. With how many of the following activities of daily living does the Caregiver provide assistance to the qualifying individual? (1 point for each – check all that apply)

 **[ ]  Bathing [ ]  Dressing [ ]  Toileting [ ]  Transferring [ ]  Walking [ ]  Eating** |  |
| 1. Does the Qualifying Individual receive assistance with any of the activities in Question 9 from any other source? **No = 1 Yes = 0**
 |  |
| 1. **\*Caregiver Stress Level:** **Little/No Stress = 0 Mild/Moderate = 1 Moderate/Severe = 2 Severe = 3**
 |  |
| **TOTAL SCORE**  |  |
| ***\*Use the “Caregiver Stress Interview” score to compute number 11*****Put the TOTAL SCORE on the top right corner of the NFCSP Assessment** |

**Name of Client (Caregiver):** **ID #:**

**CAREGIVER STRESS INTERVIEW**

***Read to Caregiver:*** The following is a list of statements which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way: Never, Rarely, Sometimes, Quite Frequently, or Nearly Always. There are no right or wrong answers.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **QUESTION** | **Never****0** | **Rarely****1** | **Some-****times****2** | **Fre-****quently****3** | **Nearly Always****4** | **SCORE** |
| 1. Do you feel that your relative asks for more help than he/she needs?
 |  |  |  |  |  |  |
| 1. Do you feel that because of the time you spend with your relative you don’t have enough time for yourself?
 |  |  |  |  |  |  |
| 1. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your Family and Work?
 |  |  |  |  |  |  |
| 1. Do you feel embarrassed over your relative’s behavior?
 |  |  |  |  |  |  |
| 1. Do you feel angry when you are around your relative?
 |  |  |  |  |  |  |
| 1. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?
 |  |  |  |  |  |  |
| 1. Are you afraid of what the future holds for your relative?
 |  |  |  |  |  |  |
| 1. Do you feel that your relative is dependent upon you?
 |  |  |  |  |  |  |
| 1. Do you feel strained when you are around your relative?
 |  |  |  |  |  |  |
| 1. Do you feel your health has suffered because of your involvement with your relative?
 |  |  |  |  |  |  |
| 1. Do you feel that you don’t have as much privacy as you would like because of your relative?
 |  |  |  |  |  |  |
| 1. Do you feel that your social life has suffered because you are caring for your relative?
 |  |  |  |  |  |  |
| 1. Do you feel uncomfortable about having friends visit you because you are caring for your relative?
 |  |  |  |  |  |  |
| 1. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?
 |  |  |  |  |  |  |
| 1. Do you feel that you don’t have enough money to care for your relative in addition to the rest of your expenses?
 |  |  |  |  |  |  |
| 1. Do you feel that you will be unable to take care of your relative much longer?
 |  |  |  |  |  |  |
| 1. Do you feel you have lost control of your life since your relative’s illness?
 |  |  |  |  |  |  |
| 1. Do you wish you could just leave the care of your relative to someone else?
 |  |  |  |  |  |  |
| 1. Do you feel uncertain about what to do about your relative?
 |  |  |  |  |  |  |
| 1. Do you feel you should be doing more for your relative?
 |  |  |  |  |  |  |
| 1. Do you feel you could do a better job in caring for your relative?
 |  |  |  |  |  |  |
| 1. Overall, do you feel burdened caring for your relative?
 |  |  |  |  |  |  |
| **\*CAREGIVERS STRESS LEVEL TOTAL** |  |

\****The Caregiver STRESS LEVEL is calculated by Questions 1-22 and will be used for Page 1 of the Caregiver Support Program Score Sheet*** Score Is Stress Level Score Is Stress Level

0 – 20 Little/No Stress 41 – 60 Moderate/Severe Stress

21 – 40 Mild/Moderate Stress 61 – 88 Severe Stress