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 **Method of Contact:** ☐ Telephone ☐ Face-to-Face ☐ Other

Assessor Name: _____ **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
☐ Black or African American
☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ Declined to Respond
☐ Other _____

Marital Status:
☐ Never Married
☐ Married
☐ Partner/Significant Other
☐ Widowed
☐ Separated
☐ Divorced

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

For Office Use Only	Total Score _____

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM
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**	
2. The Caregiver has "greatest social need". **No = 0** **Yes = 1**	
3. 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**	
4. Age of Caregiver: **Under 60 = 0** **60-74 years of age = 1** **75 years of age or older = 2**	
5. How does the Caregiver rate his/her overall health? **Good = 0** **Fair = 1** **Poor = 2**	
6. For how many qualifying individuals is this Caregiver the primary Caregiver? (1 point for each qualifying individual)	
7. 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**	
8. Is the Caregiver employed? **No = 0** **Part-time = 1** **Full-time (35 or more hours a week) = 2**	
9. 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**	
10. Does the Qualifying Individual receive assistance with any of the activities in Question 9 from any other source? **No = 1** **Yes = 0**	
11. ***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?						
2. Do you feel that because of the time you spend with your relative you don't have enough time for yourself?						
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your Family and Work?						
4. Do you feel embarrassed over your relative's behavior?						
5. Do you feel angry when you are around your relative?						
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?						
7. Are you afraid of what the future holds for your relative?						
8. Do you feel that your relative is dependent upon you?						
9. Do you feel strained when you are around your relative?						
10. Do you feel your health has suffered because of your involvement with your relative?						
11. Do you feel that you don't have as much privacy as you would like because of your relative?						
12. Do you feel that your social life has suffered because you are caring for your relative?						
13. Do you feel uncomfortable about having friends visit you because you are caring for your relative?						
14. 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?						
15. Do you feel that you don't have enough money to care for your relative in addition to the rest of your expenses?						
16. Do you feel that you will be unable to take care of your relative much longer?						
17. Do you feel you have lost control of your life since your relative's illness?						
18. Do you wish you could just leave the care of your relative to someone else?						
19. Do you feel uncertain about what to do about your relative?						
20. Do you feel you should be doing more for your relative?						
21. Do you feel you could do a better job in caring for your relative?						
22. 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