Family Caregiver Assessment Form

Welcome! Please tell us a bit about you (the caregiver) so we can offer services that best meet your needs. All your personal information is confidential. Please see the attached FAQs for more information.

Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: _____Middle Name (if applicable): _____

Last Name: _____Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Caregiver/Care Recipient Relationship

- Please check the box to confirm that you are an eligible Family Caregiver of an Older Adult:
  ☐You are an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (unpaid) provider of in-home or community care to the care recipient
- Please select the eligibility for your care recipient:
  ☐Your care recipient is an older individual (60 years of age or older) with 2+ ADL limitations; or
  ☐Your care recipient is an individual with dementia or related neurological or cognitive disorder
- What is your relationship to the care recipient?
  ☐Husband ☐Wife ☐Domestic Partner ☐Son/Son-in-Law ☐Daughter/Daughter-in-law
  ☐Sister ☐Brother ☐Grandparent ☐Parent ☐Other Relative:_____
  ☐Non-Relative:_____

Contact Information Section

Home Phone: _____Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor):_____

County: _____

City: _____ State: _____Zip: _____

Mailing address is the same as home address ☐

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

Demographics Section – Used for Anonymous Reporting to Our Funders

- Gender (select all that apply): ☐Male ☐Female ☐Non-binary/Third gender ☐Transgender ☐Another gender not listed: _____ ☐Refuse to answer question

- Ethnicity: ☐Hispanic or Latino/a/e ☐Not Hispanic or Latino/a/e ☐Refuse to answer question
- Racial Identity (select all that apply):
  ☐American Indian or Alaska Native ☐Asian or Asian American ☐Black or African American
  ☐Middle Eastern or North African ☐Native Hawaiian or Pacific Islander ☐White
  ☐Another identity not listed: _____ ☐Refuse to answer question
- Do you live alone or with others? ☐Alone ☐With others ☐Refuse to answer question
- Is your income above or at/below the amount listed for your household size in the table:
  ☐Above ☐At/below ☐Refuse to answer question

Income Levels Table

Household Size	Monthly Income	Annual Income
1	$1,304	$15,650
2	$1,763	$21,150

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

Communication Section

What is your primary language?: _____

Service Access and Support Section

- Can you access this service through another benefit or program? For example, through your care recipient's Medicaid, VA, or Medicare benefits, or food assistance programs
  ☐Yes ☐No ☐Refuse to answer question ☐I don't know
- Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select "Yes" if any of the following statements are true for you:
  - You live in a remote area, or
  - You have a health condition or disability that makes it difficult for you to access community resources, or
  - You have financial or technology challenges that make it difficult for you to access community resources, or
  - You cannot drive or use public transportation, or
  - You do not feel welcome in your community due to cultural or language barriers

  ☐Yes ☐No ☐Refuse to answer question

Emergency Contact Section

Name: _____Phone: _____

Relationship: _____ ☐Refuse to provide contact

Caregiver Needs Section

- Are you getting help from anyone with your caregiver duties?
  ☐Yes - professional/paid (formal) help ☐Yes - informal help
  ☐Yes - both formal and informal help ☐No ☐Refuse to answer question
    - If yes, please explain:_____

Modified Caregiver Strain Index

Here is a list of things that caregivers may find to be difficult. If an item applies to you, please indicate whether it applies on A Regular Basis or Sometimes. If an item does not apply to you, please mark the No column. Your situation may be slightly different, but the item could still apply.

Modified Caregiver Strain Index	Yes, on a regular basis (2 pts.)	Yes, some-times (1 pt.)	No (0 pt.)	Refuse to answer question (0 pt.)
My sleep is disturbed. For example: person I care for wanders at night; needs assistance; I can't sleep	☐	☐	☐	☐
Caregiving is inconvenient. For example: helping takes a lot of time; it's a long drive over to help	☐	☐	☐	☐
Caregiving is a physical strain. For example: lifting in or out of a chair/bed/toilet	☐	☐	☐	☐
Caregiving is confining. For example: restricts my free time; I cannot go places I enjoy	☐	☐	☐	☐
There have been family adjustments. For example: helping has disrupted my routine; there is no privacy; family arguments	☐	☐	☐	☐
There have been changes in personal plans. For example: I could not go on vacation; I cannot participate in activities that I enjoy	☐	☐	☐	☐
There have been other demands on my time. For example: other family members need me; work	☐	☐	☐	☐
There have been emotional adjustments. For example: arguments with family about caregiving; anger; sadness	☐	☐	☐	☐
Some behavior is upsetting. For example: person cared for has memory issues; outbursts	☐	☐	☐	☐
It is upsetting to find the person I care for has changed so much from their former self. For example: the care recipient is a different person than they used to be; unable to do things	☐	☐	☐	☐

Modified Caregiver Strain Index	Yes, on a regular basis (2 pts.)	Yes, some-times (1 pt.)	No (0 pt.)	Refuse to answer question (0 pt.)
There have been work adjustments. For example: I have to take time off for caregiving duties; adjusting schedules; unable to work	☐	☐	☐	☐
Caregiving is a financial strain. For example: I use personal finances for caregiving; unsure about future financial situation	☐	☐	☐	☐
I feel completely overwhelmed. For example: I worry about the person I care for; I have concerns for my future	☐	☐	☐	☐

Total Caregiver Strain Index Score: _____

Care Recipient Assessment Form

Please fill in this form about your care recipient.

Registration and Eligibility Section – Must Be Completed Prior to Service

First Name: _____Middle Name (if applicable): _____

Last Name: _____Nickname (if applicable): _____

Date of Birth: _____ Age: _____

Eligibility for the Care Recipient

- Cognitive Impairment Eligibility Screening: The care recipient has cognitive impairment; and, the care recipient needs another person to provide physical guidance or spoken instructions to keep the care recipient or others safe. ☐Yes ☐No
- The care recipient has 2 or more activity of daily living limitations ☐Yes ☐No

Contact Information Section

Does the care recipient live with the caregiver? If yes, skip to the Demographics Section ☐Yes ☐No

Home Phone: _____Cell Phone: _____

Email: _____

Home Address Line 1: _____

Home Address Line 2 (Apt/Unit/Floor):_____

County: _____

City: _____ State: _____Zip: _____

Mailing address is the same as home address ☐

Mailing Address Line 1: _____

Mailing Address Line 2 (Apt/Unit/Floor): _____

City: _____ State: _____ Zip: _____

Demographics Section – Used for Anonymous Reporting to Our Funders

- Gender (select all that apply): ☐Male ☐Female ☐Non-binary/Third gender ☐Transgender ☐Another gender not listed: _____ ☐Refuse to answer question
- Ethnicity: ☐Hispanic or Latino/a/e ☐Not Hispanic or Latino/a/e ☐Refuse to answer question
- Racial Identity (select all that apply):
  ☐American Indian or Alaska Native ☐Asian or Asian American ☐Black or African American
  ☐Middle Eastern or North African ☐Native Hawaiian or Pacific Islander ☐White
  ☐Another identity not listed: _____ ☐Refuse to answer question
- Do you live alone or with others? ☐Alone ☐With others ☐Refuse to answer question
- Is your income above or at/below the amount listed for your household size in the table:
  ☐Above ☐At/below ☐Refuse to answer question

Income Levels Table

Household Size	Monthly Income	Annual Income
1	$1,304	$15,650
2	$1,763	$21,150

Use the table to determine if your income is above or at/below the monthly or annual income listed for your household size. For each additional person, add $5,500 to annual income.

Communication Section

What is your primary language?: _____

Service Access and Support Section

- Health Insurance (select all that apply):
  ☐Medicare ☐Medicare Advantage ☐Medicaid ☐Medicaid Waiver(s) ☐VA ☐Private
  ☐None ☐Other insurance: _____ ☐Refuse to answer question
- Are you homebound? Select "Yes" if any of the following statements are true for you:
  - You need the help of another person to leave your home, or
  - You have a health condition or disability that makes it difficult to leave your home on a regular basis, or
  - You are only able to leave your home infrequently and for short periods of time

  ☐Yes ☐No ☐Refuse to answer question
- Are you isolated from community resources? Examples of community resources include stores, banks, health services, and senior center activities. Select "Yes" if any of the following statements are true for you:
  - You live in a remote area, or
  - You have a health condition or disability that makes it difficult for you to access community resources, or
  - You have financial or technology challenges that make it difficult for you to access community resources, or
  - You cannot drive or use public transportation, or
  - You do not feel welcome in your community due to cultural or language barriers

  ☐Yes ☐No ☐Refuse to answer question

Emergency Contact Section

Name: _____Phone: _____

Relationship: _____ ☐Refuse to provide contact

Nutrition Screening Section

Nutrition Risk Score

Determine your nutritional health. If the statement is true for you, check the box in the "Yes" column and add the points in the "Yes Score" column to your total score.

Nutrition Risk Score Questions	Yes	No	Refuse to Answer Question	Yes Score
1. Do you have an illness or condition that has made you change the kind and/or amount of food you eat?	☐	☐	☐	2
2. Do you eat fewer than 2 meals per day?	☐	☐	☐	3
3. Do you eat few fruits, vegetables, or milk products?	☐	☐	☐	2
4. Do you have 3 or more drinks of beer, liquor, or wine almost every day?	☐	☐	☐	2
5. Do you have tooth or mouth problems that make it hard for you to eat?	☐	☐	☐	2
6. Are there times you do not have enough money to buy the food you need?	☐	☐	☐	4
7. Do you eat alone most of the time?	☐	☐	☐	1
8. Do you take 3 or more different prescribed or over the counter drugs a day?	☐	☐	☐	1
9. Without wanting to, have you lost or gained 10 pounds in the last 6 months?	☐	☐	☐	2
10. Are there times you're physically unable to shop, cook, and/or feed yourself?	☐	☐	☐	2

Total Nutrition Risk Score (Total "Yes" Score): _____

Total Nutrition Risk Score Meaning: 0-2 = No Risk, 3-5 = Moderate Risk, 6 or more = High Risk

If you are at high nutrition risk – speak with a qualified health or social service professional.

Activities of Daily Living – Must Be Completed for Eligibility

For each activity, please mark the level of help the care recipient needs.

Activities of Daily Living	Independent: I don't need any help with this activity	Some help: I need some help or reminders from another person, but I can do parts of this activity on my own	Dependent: I always need help from another person to do this activity
1. Bathing or showering	☐	☐	☐
2. Dressing - Putting on and taking off clothing and shoes	☐	☐	☐
3. Using the bathroom - Getting to and on/off the toilet, managing clothing, wiping	☐	☐	☐
4. Transferring In/Out of Bed/Chair - Getting in and out of sitting or lying positions	☐	☐	☐
5. Walking/Getting Around the House	☐	☐	☐
6. Eating and drinking	☐	☐	☐

Comments on ADLs: _____

Instrumental Activities of Daily Living

For each activity, please mark the level of help the care recipient needs.

Instrumental Activities of Daily Living	Independent: I don't need any help with this activity	Some help: I need some help or reminders from another person, but I can do parts of this activity on my own	Dependent: I always need help from another person to do this activity	Refuse to Answer Question
1. Meal Preparation – Planning, making, and cleaning up meals	☐	☐	☐	☐

Instrumental Activities of Daily Living	Independent: I don't need any help with this activity	Some help: I need some help or reminders from another person, but I can do parts of this activity on my own	Dependent: I always need help from another person to do this activity	Refuse to Answer Question
2. Shopping – selecting and paying for food, household supplies, clothing, and other items	☐	☐	☐	☐
3. Medication Management – getting prescriptions filled and taking medications as prescribed	☐	☐	☐	☐
4. Money Management – budgeting, using cards and bank accounts, paying bills	☐	☐	☐	☐
5. Using a Telephone – making and receiving calls	☐	☐	☐	☐
6. Light Housework – tidying up, sweeping, vacuuming, mopping, cleaning kitchen and bathroom surfaces, taking out garbage	☐	☐	☐	☐
7. Heavy Housework – deep cleaning the home, moving light furniture to clean under/behind	☐	☐	☐	☐
8. Transportation – driving, walking, or using other forms of available transportation, like buses	☐	☐	☐	☐

Comments on IADLs: _____

- Does anyone help you with ADL or IADL activities? ☐Yes ☐No ☐Refuse to answer question
    - If yes, who is assisting you? _____

Are you interested in learning about nutrition and a healthy diet? If yes, you're invited to enroll in Text2LiveHealthy, a nutrition education program delivered to you via text message. Scan this QR code with your phone's camera to enroll or text the word FRUIT to 97699.Message & Data Rates May Apply. Text HELP for information. Text STOP to 97699 to opt out. No purchase necessary. For Privacy Policy and Terms and Conditions, visit: https://coloradosph.cuanschutz.edu/text2livehealthy

Disclosures and Waivers

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service providers and I give my consent to do so.

Signature: _____

Date: _____

If filled out by someone other than the caregiver client (for example a caregiver or assessor, please check here ☐ and sign below)

Filled out by: _____

Date: _____

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