Clear Form

- ☐ UCR
- ☐ OR Access
- ☐ Mailing List
- ☐ Email to CM
- ☐ Mailed to Client
- ☐ Letter of guarantee mailed

# Caregiver Relief Fund Customer Intake Form

Multnomah County

**SEND TO**: Multnomah County Aging, Disability, and Veterans Services
PO Box 40488 Portland, OR 97240
or by **secure/encrypted** email to: family.caregiver@multco.us
Phone: 503-988-8210

Date | Referral Source | Case Manager Load Code / Agency

**CLIENT email** for updates on upcoming caregiver events:

## Caregiver Information

Name • Last | First | MI

DOB | Email | Phone

Mailing Address | City | State | Zip

Prime # | Gender ☐ Female ☐ Male ☐ Transgender

**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

**Race** (check all that apply)

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Asian
- ☐ Black or African American
- ☐ Other

Check any of the following if it restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently:

- ☐ Mental disability
- ☐ Limited English proficiency?
- ☐ Isolation caused by racial or ethnic status
- ☐ Living in a rural situation-census tract

## Caregiver Relationship to Care-receiver

- ☐ Husband
- ☐ Wife
- ☐ Son/Son-in-Law
- ☐ Daughter/Daughter-in-Law
- ☐ Non-Relative
- ☐ Other relative
- ☐ Relationship not reported

## Grandparents & Other Elderly Caregivers age 55 and over caring for a relative child age 18 or younger

Relationship to Care-receiver ☐ Grandparents ☐ Other Relative | Describe relationship

How many children under age 18 are you caring for?

Does a parent of the child/children also reside in your household? ☐ YES ☐ NO

List any disability or special need, including learning disability, mental health service or special need of children being raised by grandparent/elder relative

## Grandparents & Other Elderly Caregivers (including parents) age 55 and over caring for a relative age 18-59 with a disability

Relationship to Care-receiver ☐ Grandparent ☐ Other Relative | Describe relationship

Describe the disability /special need of the care recipient

Does a parent of the care recipient also reside in your household? ☐ YES ☐ NO

**Caregiver Household Monthly Income:** $

Income Source ☐ Unemployed ☐ Employeed ☐ SSB ☐ Other | Describe

Number in Household

If the annual income does not meet 300% of federal poverty, you can note the **average monthly medical expenses** of the caregiver household $

Describe medical expenses

## Other Natural Supports

List other family, friends, neighbors, etc., who assist the family caregiver. What assistance do they provide and how frequently?

## Person In Care Information

Name • Last | First | MI

DOB | Phone

Current Address | City | State | Zip

Prime # | Gender ☐ Female ☐ Male ☐ Transgender

**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Not Reported

**Race** (check all that apply)

☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Asian ☐ Black or African American ☐ Other

Additional Grandchild(ren) name(s), DOB, ethnicity and race (if applicable)

Diagnoses of the Care Receiver (if a child, please note any special needs)

Activities of Daily Living

Put a check by the level of care needed by the care recipient which is provided by the family caregiver applying for the relief grant. (Not applicable for grandparents raising grandchildren)

| | | | | |
|---|---|---|---|---|
| Bathing..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Mobility..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Transferring..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Dressing..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Personal Hygiene..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Toileting..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |
| Eating..... | ☐ Independent | ☐ Minimal Assistance | ☐ Substantial Assistance | ☐ Dependent |

Does the care receiver have a diagnosis of Alzheimer's or other related disorder with neurological and organic brain dysfunction which requires the family caregiver provide substantial assistance for that persons care and/or safety? ☐ YES ☐ NO

Diagnoses

Is the caregiver recipient receiving hospice or palliative care services? ☐ YES ☐ NO

Diagnoses

Is the care receiver a veteran? ..... ☐ YES ☐ NO

Is the care receiver married to a veteran or a widow(er) of a veteran? ..... ☐ YES ☐ NO

Has the care receiver applied for veterans' services? ..... ☐ YES ☐ NO

Is the care receiver receiving in home services through veterans services? ..... ☐ YES ☐ NO

## Caregiver Relief Fund Customer Intake Form **Care Plan Page**

Caregiver Name

If multiple agencies are requested in a plan, list all agency names, contact information and amount designated per agency in the boxes below. Family caregivers need to choose **ONE** of the following plans.

**RESPITE Plan**—Request the amount needed **SPECIFIC** to this caregiver's needs

Type of respite requested • Companion, Personal Care, Housekeeping Adult Day Program, Respite

- How many hours of respite does the caregiver need to meet their respite goal?
- **When** does the caregiver want to start respite services (month/year)?

| Respite Agency Name | Agency Contact Person and Phone Number | Amount of Funds Requested |
|---|---|---|
| | | $ |
| | | $ |
| | Amount of Funds Requested | $ 0.00 |

**SUPPLEMENTAL Service Plan**

**Supplemental** Services Requested • if more space is needed, please attach separate list of items, cost, vendor & phone

| Item | Cost | Vendor/Provider Name and Phone Number |
|---|---|---|
| | $ | |
| | $ | |
| | $ | |
| | $ | |
| Amount of Funds Requested | $ 0.00 | |

- **When** does the caregiver want to purchase the supplemental service (month/year)?

**COUNSELING Grant**

- Amount of Funds Requested $
- Agency/Counselor Contact Person and phone number

**GRANDPARENT/ELDER RELATIVE Grant** • including those caring for an adult with a disability

**The amount of funds requested should reflect care plan**

- **When** does the caregiver want to purchase the supplemental service (month/year)?
- Respite and/or Supplemental Service Requested
- Amount of Funds Requested $
- Agency Contact Person and phone number

**FOR OFFICIAL USE ONLY**

Annual Income $

Type of Grant Given ☐ Respite ☐ Supplemental Service ☐ Counseling ☐ Grandparent/Relative

Total Award Amount Requested $ Award Given $

Start Date End Date

**Note**: changes can be made to the care plan with prior approval by the Program Coordinator.