[ ] UCR **CAREGIVER RELIEF FUND CUSTOMER INTAKE FORM**

[ ] Or Access SEND via SECURE email to: family.caregiver@multco.us

[ ] Mailing List Or mail to: Family Caregiver Support Program, PO Box 40488

[ ] E-mail to CM Portland Or 97240, Phone: 503.988.8210 or 503.988.3646

[ ] Mailed to Client

[ ] Letter of Guarantee Mailed

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| Date:       | Referral Source:       | Case Manager Load Code / Agency:       |
|  ***CLIENT email address for updates on upcoming caregiver events****:* |
| **CAREGIVER INFORMATION** |
| Name:      |       |       |
|  *Last First MI* |
| PRIME #       | DOB:      | Email:      | Phone:      |
|       |       |       |       |
| *Mailing Address City State Zip* |
| Gender [ ]  Female [ ]  Male [ ] Transgender |
| **Ethnicity:**[ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Not Reported |
| **Race:** (check all that apply)[ ]  White [ ]  American Indian / Alaska Native [ ]  Native Hawaiian or other Pacific Islander[ ]  Asian [ ]  Black or African American [ ]  OtherCheck 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:      |
| **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 (non parental) age 55 and over caring for a relative age 18-****59 with a disability.**[ ]  Grandparent [ ]  other Relative (relationship)     **Describe the disability /special need of the care recipient**:     **Does a parent of the care recipient also reside in your household? yes** **[ ]  no** **[ ]**  |

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| **Caregiver Household Monthly Income: $****Income Source:** [ ]  Unemployed [ ]  Employed [ ]  SSB [ ]  Other**Number in Household:** **If the annual income does not meet 300% of federal poverty, you can note the average monthly medical expense of the caregiver household. $****Describe medical expenses:****OTHER NATURAL SUPPORTS:****Please list other family, friends, neighbors etc, who assist the family caregiver. Please note what assistance they provide and how frequently:**  |
| **PERSON IN CARE INFORMATION** |
| Name:       |       |       |
|   *Last First MI* |
| Prime/Agency #       | DOB:       | Phone:       |
|       |       |       |       |
|  *Current Address City State Zip* |
| Gender: [ ]  Female [ ]  Male [ ] Transgender |
| **Ethnicity:** [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Not Reported |
| **Race:** (check all that apply)[ ]  White [ ]  American Indian / Alaska Native [ ]  Native Hawaiian or Other Pacific Islander[ ]  Asian [ ]  Black or African American [ ]  Other |
| **Additional Grandchild(ren) name(s), dob, ssn, ethnicity and race (if applicable):** **Diagnoses of the Care Receiver**      **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 client to provide 24/7 care for the care recipient? (this includes care recipients dependent on cueing to do Activities of Daily Living and/or who are unable to be left alone due to safety issues.**Yes [ ]  No [ ]  Diagnoses:     **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. (NA for grandparents raising grandchildren)Bathing [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentMobility [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentTransferring [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentDressing [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentPersonal hygiene [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentToileting [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependentEating [ ]  independent [ ]  minimal assistance [ ]  substantial assistance [ ]  dependent**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 Veteran Services? yes [ ]  no [ ]** **Is the care receiver receiving in home services through Veterans Services? yes [ ]  no [ ]**  |

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| **CAREGIVER RELIEF FUND CUSTOMER INTAKE FORM CARE PLAN PAGE** |
| **Caregiver Name:** **Note: (If multiple agencies are requested in a plan, please note 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 Only Plan-Request the amount needed SPECIFIC to this caregiver’s needs (maximum award $600):** **T**ype 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 / Agencies chosen:      Respite Agency / Agencies Contact Person(s) and phone number:      Amount of Funds Requested:       |

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| **Supplemental Service Only Plan-(Total allowed is $600)****Request the amount needed SPECIFIC to this caregiver’s needs:**Supplemental Service(s) Requested and cost of items to be purchased:      **When does the caregiver want to purchase the supplemental service (month/year)?**Provider(s) of Supplemental Service and Phone number:      Amount of Funds Requested:       |

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| **Combination Respite and Supplemental Service Plan (Total allowed is $600):****Part A:**Type of respite requested (Companion, Personal Care, Housekeeping, Adult Day Program, Facility Respite):     **When does the caregiver want the respite to start (month/year)?**Respite Agency / Agencies Chosen:      Respite Agency / Agencies Contact Person(s) and phone number:      Amount of Funds Requested:      **Part B:**Supplemental Services Requested:       (medical equipment, medical alert, incontinence supplies, caregiver counseling, caregiver self-care activity, legal assistance related to caring for an elder, and caregiver related training, etc.)**When does the caregiver want to purchase the supplemental service (month/year)?**Provider(s) of Supplemental Service and phone number:      Amount of Funds Requested       |
| **Grandparent/Elder Relative Grant (including those caring for an adult with a severe disability):**(Grant amounts available: **a maximum of $200 per child** being raised by the grandparent/relative elder. The amount of funds requested should reflect care plan).**When does the caregiver want to purchase the respite/supplemental service (month/year)?**Respite and / or Supplemental Service Requested:      Amount of Funds Requested:      Agency Contact Person and phone number:       |

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| Annual Income:       |
| Type of Grant Given: [ ]  Respite only [ ]  Supplemental Service only [ ]  Combo-Respite / SS |
| 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.

Form updated July 1, 2016