UCR **Caregiver Relief Fund Customer Intake Form**

OR Access **SEND TO**: Multnomah County Aging, Disability, and Veterans Services

Mailing List PO Box 40488 Portland, OR 97240

Email to CM or by secure/encrypted email to: family.caregiver@multco.us

Mailed to Client

Letter of guarantee mailed Phone: 503-988-8210

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| 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 / 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: | | | | | | | | | | |
| **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.** 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 | |
| DOB: | Phone: | | | | | | | |
|  | | | |  |  | | |  |
| Current Address | | | | City | State | | | Zip |
| Prime/Agency # | | 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, ethnicity and race (if applicable):**  **Diagnoses of the Care Receiver**  **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  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**

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| **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 $800**):  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 / 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 $300)**  **Request the amount needed SPECIFIC to this caregiver’s needs:**  Supplemental Service(s) Requested (include all items requested, cost of items to be purchased and vendor:  **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 $800):**  **Part A:**  Type of respite requested (Companion, Personal Care, Housekeeping, Adult Day Program, Facility Respite):    **How many hours of respite does the caregiver need to meet their respite goal?**  **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 (**maximum allowed $300**): (medical equipment, medical alert, incontinence supplies, legal assistance related to caring for an elder, and caregiver self care, 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 $ |
| **Counseling Grant: (Maximum allowed is $300). This is an additional grant available.**  Amount of Funds Requested: $  Agency/Counselor Contact Person and phone number: |
| **Grandparent/Elder Relative Grant (including those caring for an adult with a 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: |

***For Official Use Only***

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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 June 27, 2017