Larimer County Office on Aging Family Caregiver Support Program Assessment

Updated June 3, 2021

Caregiver Profile				**Date of Assessment:**
First Name:		Last Name:		Middle Initial:
Date of Birth:	Age:	Gender: ☐ Male ☐ Female ☐ Other	Are you a veteran? ☐ Yes ☐ No	
What is your primary language?		What is your race?	Are you Hispanic or Latino? ☐ Yes ☐ No	
Are you visually impaired (cannot be corrected with glasses)? ☐ Yes ☐ No			Are you receiving Medicaid? ☐ Yes ☐ No	
Do you live alone? ☐ Yes ☐ No	Are you married? ☐ Yes ☐ No	How many people live in your household?		
Is your monthly income below $1,073? ☐ Yes ☐ No				
Residential Street Address:		Mailing Address - Street/P.O. Box:		
Apartment or Unit # (if applicable):		Mailing City or Town:		
Residential City or Town:		Mailing State, Zip Code:		
Residential State, Zip Code:		Email Address:		
Primary Phone # (including area code):		Secondary Phone # (including area code):		
Are you a grandparent, raising grandchildren? ☐ Yes ☐ No		Do you have a back-up plan for care? ☐ Yes ☐ No		
Are you interested in receiving nutrition counseling? ☐ Yes ☐ No				
Relationship to care receiver: ☐ Spouse ☐ Daughter ☐ Son ☐ In-Law ☐ Friend ☐ Other *(specify)*:				
Are you getting help from anyone with your caregiver duties? ☐ Yes ☐ No		If yes, please explain below:		
What additional help is needed:				
Please tell us what is your biggest concern regarding your caregiving situation:				

I have been informed of the complaint/grievance policy for consumers. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Caregiver Signature_____ Date_____

Care Receiver Profile			
First Name:	Last Name:		Middle Initial:
Date of Birth: / /	Age:	Gender: ☐ Male ☐ Female ☐ Other	Veteran: ☐ Yes ☐ No
Primary language:		Race:	Hispanic or Latino: ☐ Yes ☐ No
Visually impaired (cannot be corrected with glasses): ☐ Yes ☐ No			Receiving Medicaid: ☐ Yes ☐ No
Live alone: ☐ Yes ☐ No	Married: ☐ Yes ☐ No		
Is your monthly income below $1,073? ☐ Yes ☐ No			
Residential Street Address:		Mailing Address - Street/P.O. Box:	
Apartment or Unit # (if applicable):		Mailing City or Town:	
Residential City or Town:		Mailing State, Zip Code:	
Residential State, Zip Code:		Email Address:	
Primary Phone # (including area code):		Secondary Phone # (including area code):	

Nutrition Checklist: (*please check if the below statements are true for the care receiver*)	**Yes**	**No**	**Yes Score**
I have an illness or condition that made me change the kind and/or amount of food I eat.	☐	☐	2
I eat fewer than 2 meals per day.	☐	☐	3
I eat few fruits or vegetables or milk products.	☐	☐	2
I have 3 or more drinks of beer, liquor, or wine almost every day.	☐	☐	2
I have tooth or mouth problems that make it hard for me to eat.	☐	☐	2
I don't always have enough money to buy the food I need.	☐	☐	4
I eat alone most of the time.	☐	☐	1
I take 3 or more different prescribed or over the counter drugs a day.	☐	☐	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	☐	☐	2
I am not always physically able to shop, cook and/or feed myself.	☐	☐	2

Are you interested in receiving nutrition counseling? ☐ Yes ☐ No

Please check how much assistance you or another person provides or the care receiver with the activities of daily living below:					
ADLs (Activities of Daily Living)	**Yes**	**No**	**IADLs (Instrumental Activities of Daily Living)**	**Yes**	**No**
Bathing or showering	☐	☐	Managing financials or bills	☐	☐
Dressing	☐	☐	Shopping	☐	☐
Mobility around the home	☐	☐	Managing medical tasks (i.e., medication)	☐	☐
Getting to & using the toilet	☐	☐	Preparing meals	☐	☐
Eating (not preparation of food)	☐	☐	Completing ordinary housework (i.e. laundry, vacuuming)	☐	☐
Getting in & out bed/chairs	☐	☐	Using the telephone	☐	☐
Managing personal care needs (i.e., incontinence products)	☐	☐	Providing or accessing transportation	☐	☐
Do you provide supervision for the care receiver due to memory or behavioral concerns? ☐ Yes ☐ No					

I have been informed of the complaint/grievance policy for consumers. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so.

Care Receiver Signature_____ Date_____

Signature of legal representative or guardian _____ Date_____

Respite Care

All caregivers need an occasional break from the demands of caring for someone else. Respite care will help you- and the person you care for. Respite care includes:

- Care at home, daily care outside the home (i.e. adult day program), or overnight care at an assisted living or skilled nursing facility for a number of days
- Care can be provided by homecare agencies, private caregivers or arranged through family and friends

(See back page)

Caregiver Respite Voucher

A respite voucher may be available to help you purchase in-home services or other types of respite care personally suited to you and the person you care for.

☐ **Please check if you are interested in applying for the voucher.**

Please describe, being as specific as possible, how you plan to use the voucher to give yourself an occasional break and/or some back-up support:

Please return "Caregiver's Profile" and "Care Receiver's Profile" to:

Mail: Larimer County Office on Aging
1501 Blue Spruce Drive, Fort Collins, Colorado 80524
Fax:(970) 498-6304, Attn: Family Caregiver Support Program
Email: adrc@larimer.org

Any questions please call the Larimer County Office on Aging at (970) 498-7750