

**COUNTY OF SAN MATEO AGING AND ADULT SERVICES - OLDER AMERICAN ACT PROGRAMS
FAMILY CAREGIVER SUPPORT PROGRAM
CARING FOR ELDERLY**

SECTION 1 – Service Information

Provider Name:	Registration / Assessment Date:
	Termination Date:
	Reason:

SECTION 2 – Eligibility Criteria

<p>Caregiver Caring for Elderly Eligibility Criteria</p> <p>1. Is the Care Receiver an older individual (60 years of age or older) <u>or</u> an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is the Caregiver an adult (18 years of age or older) family member or another individual (e.g., friend or neighbor) who is an informal (i.e., unpaid) provider of in-home or community care to an "elderly" Care Receiver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Title III E Family Caregiver Support Program Services To Be Provided

<p><input type="checkbox"/> Support Services</p> <p><input type="checkbox"/> Respite Care Services <i>(Care Receiver has to have 2 or more ADL limitations or a cognitive impairment)</i></p> <p><input type="checkbox"/> Supplemental Services: <i>(Care Receiver has to have 2 or more ADL limitations or a cognitive impairment)</i></p> <p><input type="checkbox"/> Access Assistance</p> <p><input type="checkbox"/> Information Services</p>

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SECTION 3 — FCSP Caregiver Information

Unique Participant ID: _____

Caregiver Personal Data (Please Print):	
First Name:	Middle Initial:
Last Name:	
Birth Date:	
Home Phone #:	()
What is your gender: (Check only one)	a. Male b. Female c. Transgender Female to Male d. Transgender Male to Female e. Genderqueer / Gender Non-binary f. Not listed, please specify: _____ g. Declined / not stated
What was your sex at birth: (Check only one)	a. Male b. Female c. Declined / not stated
How do you describe your sexual orientation or sexual identity: (Check only one)	a. Straight / Heterosexual b. Bisexual c. Gay / Lesbian/Same-Gender Loving d. Questioning / Unsure e. Not listed, please specify: _____ f. Declined / not stated
Residential Address:	
City:	
Zip Code:	

Federal Poverty Level (FPL): \$ 1,255 or less per month-1 person \$ 1,703 or less per month-2 persons	<input type="checkbox"/> Above FPL <input type="checkbox"/> At or below FPL <input type="checkbox"/> Declined to State
Lives Alone:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to State
Rural:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to State
Rural Area in San Mateo County	
94018 El Granada & Princeton-by-the-Sea 94019 Half Moon Bay 94020 La Honda 94021 Loma Mar	94037 Montara 94038 Moss Beach 94060 Pescadero 94074 San Gregorio
Ethnicity:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Declined to State
Race: (Check only one)	
<input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Multiple Race	<input type="checkbox"/> Black <input type="checkbox"/> Other Race <input type="checkbox"/> White
Asian:	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian	<input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Other Asian
<input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese	
Hawaiian/Other Pacific Islander:	
<input type="checkbox"/> Guamanian <input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan
<input type="checkbox"/> Declined to State	
Care Receiver _____ Care Receiver _____ Care Receiver _____	
Relationship to Care Receiver:	<input type="checkbox"/> Daughter / Daughter-in-law <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Husband <input type="checkbox"/> Other Relative <input type="checkbox"/> Wife <input type="checkbox"/> Declined to State
	<input type="checkbox"/> Grandparent <input type="checkbox"/> Non-Relative <input type="checkbox"/> Son / Son-in-law
Relationship Status of Care Giver	<input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State
	<input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated
Employment Status of Caregiver	<input type="checkbox"/> Full Time <input type="checkbox"/> Retired <input type="checkbox"/> Declined to State
	<input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed

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SECTION 4 — FCSP Care Receiver Information

Please complete a separate form for each care receiver

Unique Participant ID: _____

First Name:		Middle Initial:	
Last Name:			
Birth Date:			
Home Phone #:	()		
What is your gender: (Check only one)	a. Male b. Female c. Transgender Female to Male d. Transgender Male to Female e. Genderqueer / Gender Non-binary f. Not listed, please specify: _____ g. Declined / not stated		
What was your sex at birth: (Check only one)	a. Male b. Female c. Declined / not stated		
How do you describe your sexual orientation or sexual identity: (Check only one)	a. Straight / Heterosexual b. Bisexual c. Gay / Lesbian/Same-Gender Loving d. Questioning / Unsure e. Not listed, please specify: _____ f. Declined / not stated		
Residential Address:			
City:			
Zip Code:			

Federal Poverty Level (FPL): \$ 1,255 or less per month-1 person \$ 1,703 or less per month-2 persons	<input type="checkbox"/> Above FPL <input type="checkbox"/> At or below FPL <input type="checkbox"/> Declined to State
Lives Alone:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to State
Rural:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Declined to State
Rural Areas in San Mateo County	
94018 El Granada & Princeton-by-the-Sea 94019 Half Moon Bay 94020 La Honda 94021 Loma Mar	94037 Montara 94038 Moss Beach 94060 Pescadero 94074 San Gregorio
Ethnicity:	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Declined to State
Race: (Check only one)	
<input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Black <input type="checkbox"/> Multiple Race <input type="checkbox"/> Other Race <input type="checkbox"/> White	
Asian: <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Other Asian <input type="checkbox"/> Vietnamese	
Hawaiian/Other Pacific Islander: <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Declined to State	
Care Giver _____	
Relationship Status of the Care Receiver	<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (never married) <input type="checkbox"/> Widowed <input type="checkbox"/> Declined to State

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**SECTION 5 – FCSP Caring for the Elderly - Care Receiver
 ADL and IADL (Activities of Daily Living and Instrumental Activities of Daily Living)**

Required for the Care Receiver only in Support Services, Respite Care, and Supplemental Services.

1 - Independent, 2 - Verbal Assistance, 3 - Some Human Help, 4 - Lots of Human Help, 5 - Dependent, X - Declined to State

ADLs:	
Bathing	
Dressing	
Eating	
Toileting	
Transferring In / Out of Bed / Chair	
Walking	
Notes:	

IADLs:	
Heavy Housework	
Light Housework	
Meal Preparation	
Medication Management	
Money Management	
Shopping	
Transportation	
Using Telephone	
Notes:	