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

Caregiver Caring for Elderly Eligibility Criteria

1. Is the Care Receiver an older individual (60 years of age or older) ***or*** an individual (of any age) with Alzheimer's disease or related disorder with neurological and organic brain dysfunction? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Title III E Family Caregiver Support Program Services To Be Provided

☐ **Support Services**

☐ **Respite Care Services** *(Care Receiver has to have 2 or more ADL limitations or a cognitive impairment)*

☐ **Supplemental Services:** *(Care Receiver has to have 2 or more ADL limitations or a cognitive impairment)*

☐ **Access Assistance**

☐ **Information Services**

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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): $ 1,041 or less per month-1 person $ 1,410 or less per month-2 persons	☐ Above FPL ☐ At or below FPL ☐ Declined to State
Lives Alone:	☐ No ☐ Yes ☐ Declined to State
Rural:	☐ No ☐ Yes ☐ 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:	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to State

Race: (Check only one)

☐ American Indian / Alaska Native ☐ Black
☐ Multiple Race ☐ Other Race ☐ White

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Other Asian ☐ Vietnamese

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian
☐ Other Pacific Islander ☐ Samoan ☐ Tongan

☐ Declined to State

Care Receiver _____
Care Receiver _____
Care Receiver _____

Relationship to Care Receiver:	☐ Daughter / Daughter- in-law ☐ Domestic Partner ☐ Grandparent ☐ Husband ☐ Non-Relative ☐ Other Relative ☐ Son / Son-in-law ☐ Wife ☐ Declined to State
Relationship Status of Care Giver	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (never married) ☐ Widowed ☐ Declined to State
Employment Status of Caregiver	☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Declined to State

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SECTION 4 — FCSP Care Receiver Information

Unique Participant ID:_____

Please complete a separate form for <u>each care receiver</u>

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): $ 1,041 or less per month-1 person $ 1,410 or less per month-2 persons	☐ Above FPL ☐ At or below FPL ☐ Declined to State
Lives Alone:	☐ No ☐ Yes ☐ Declined to State
Rural:	☐ No ☐ Yes ☐ 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:	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to State

Race: (Check only one)

☐ American Indian / Alaska Native ☐ Black
☐ Multiple Race ☐ Other Race ☐ White

Asian:
☐ Asian Indian ☐ Cambodian ☐ Chinese
☐ Filipino ☐ Japanese ☐ Korean
☐ Laotian ☐ Other Asian ☐ Vietnamese

Hawaiian/Other Pacific Islander:
☐ Guamanian ☐ Hawaiian
☐ Other Pacific Islander ☐ Samoan ☐ Tongan

☐ Declined to State

Care Giver _____

Relationship Status of the Care Receiver	☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Single (never married) ☐ Widowed ☐ Declined to State

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:	