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 related disorder with neurological and organic brain dysfunction 2. Is the Caregiver an adult (18 years of age or older) family mentan informal (i.e., unpaid) provider of in-home or community care 	nn? Yes No mber or another individual (e.g., friend or neighbor) who is			
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 mo	ore ADL limitations or a cognitive impairment)			
☐ Access Assistance				
☐ Information Services				

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SECTION 3 — FCSP Caregiver Information

			•				
Caregiver Persona	Il Data (Please Prin	t):	Federal Pover		_	Above FPL	
First Name:		Middle		per month-1 person		At or below FPL	
		Initial:	- \$ 1,043 or less p	er month-2 persons	Ш	Declined to State No	
Last Name:			Lives Alone:		lH	Yes	
Birth Date:						Declined to State	
Home Phone #:	()		Rural:		=	No	
	a. Male		7		_	Yes Declined to State	
	b. Female		Rural Area in S	San Mateo County	Ш	Declined to State	
	c . Transgender F	emale to Male	94018 El Gran		044	207.14	
What is your gender (Check only one)	d. Transgender N	d. Transgender Male to Female		Princeton-by-the-Sea		94037 Montara 94038 Moss Beach	
(Check only one)	e. Genderqueer /	e. Gendergueer / Gender Non-binary		94019 Half Moon Bay		94060 Pescadero	
	f. Not listed, plea	ase specify:	94020 La Hono			074 San Gregorio	
	g. Declined / not	. ,	94021 Loma M	ıar	\vdash	Hispanic/Latino	
What was your sex a	a. Male		Ethnicity:			Not Hispanic/Latino	
birth:	b. Female					Declined to State	
(Check only one)	c. Declined / not	stated	Race: (Check o	nly one)			
	a. Straight / Hete	erosexual	American Ir	ndian / Alaska Native		Black	
How do you describ			☐ Multiple Ra	☐ Multiple Race ☐ Other Race ☐ White Asian:		White ■	
your sexual		/Same-Gender Loving	Asian:				
orientation or sexua	d. Questioning /	J	Asian India	Asian Indian Cambodian Chinese			
identity: (Check only	heck only e. Not listed, please specify:		Filipino			☐ Korean	
one)	f. Declined / not	· •	Laotian	Other Asian	I	Vietnamese	
				Pacific Islander:			
Residential Address): 		Guamanian Other Pacif		vallal noan		
City:			Declined to	_	iouri	rongan	
Zip Code:							
Lip Code.							
Have you ever conved	Are you the angues	If you identify so being military	Care Receiver				
Have you ever served in the United States	Are you the spouse, legal partner, parent,	If you identify as being military affiliated, check below if: "I cons	ent to Relationship	Daughter / Dau	ahte	r- in-law	
military?	or child of a person	this agency and the California	to Care	Domestic Partr		Grandparent	
□ Voo	who is serving in or who has served in the	Department of Aging transmitting my name,	Receiver:	Husband		☐ Non-Relative	
Yes □ No	United States military?	address, mailing address, and m		Other Relative		Son / Son-in-law	
Declined / not		telephone number to the Depart		☐ Wife☐ Declined to Sta	ıtο		
stated	Yes	of Veterans Affairs only for the	Relationship	Divorced	ic	Domestic Partner	
	☐ No ☐ Declined / not	purpose of receiving additional information on veterans benefits	• • • • • • • • • • • • • • • •	Married	İ	Separated	
	stated	which I may be eligible. I unders		Single (never m	narrie	ed)	
		that this consent is valid for 12		Widowed			
		months."	For 1 1	Declined to Sta	te	□ D- 4 T'	
		☐ Yes ☐ No	Employment Status of	☐ Full Time☐ Retired		Part Time	
		Contact the California Departme	nt Caregiver	Declined to Sta	ite	Unemployed	
		of Veterans Affairs (CalVet) to determine eligibility for services	Caregiver	Documed to ota			
		and supports www.calvet.ca.gov	or				
_		1-800-952-5626.					

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SECTION 4 — FCSP Care Receiver Information

Please complete a separate form for each care receiver

r roddo dorriph	oto a ooparato form	TOT OCCUPANT			
First Name:		Middle Initial:	Federal Poverty Level (FPL): \$ 1,215 or less per month-1 person	Above FPL At or below FPL	
Last Name:			\$ 1,643 or less per month-2 persons	Declined to State	
Birth Date:			, ,	□ No	
Home Phone #:	()		Lives Alone:	Yes	
Tionic i none #.	a. Male			Declined to State	
	b. Female			□ No	
		Comple to Male	Rural:	Yes Declined to State	
What is your	c. Transgender F		Rural Areas in San Mateo County		
gender: (Check only one)	d. Transgender N		94018 El Granada &	94037 Montara 94038 Moss Beach 94060 Pescadero 94074 San Gregorio	
		Gender Non-binary	Princeton-by-the-Sea		
	•	ase specify:	94019 Half Moon Bay		
	g. Declined / not	stated	94020 La Honda		
What was your sex	a. Male		94021 Loma Mar		
at birth:	b. Female		Ethnicity:	Hispanic/Latino Not Hispanic/Latino	
(Check only one)	c. Declined / not	stated	Etimicity.	Declined to State	
	a. Straight / Hete	erosexual	Race: (Check only one)		
How do you	b. Bisexual		American Indian / Alaska Native	Black	
describe your	c. Gay / Lesbian	/Same-Gender Loving	Multiple Race Other Race	<u>=</u>	
sexual orientation	d. Questioning /	Unsure	Asian:		
(Check only one)	r sexual identity:		Asian Indian Cambodian	☐ Chinese	
(, , , , , , , , , , , , , , , , , , ,	f. Declined / not	stated	Filipino Japanese	☐ Korean	
Residential			Laotian Other Asian	n 🔲 Vietnamese	
Address:			Hawaiian/Other Pacific Islander:		
City:			☐ Guamanian ☐ Haw	<i>r</i> aiian	
7in Cada:			Other Pacific Islander Sam	noan 🔲 Tongan	
Zip Code:			Declined to State		
Have you ever served in the United States	Are you the spouse, legal partner, parent,	If you identify as being military affiliated, check below if: "I consent	Care Giver		
military?	or child of a person	to this agency and the California	Relationship Divorced	Domestic Partner	
	who is serving in or	Department	Status of the Married	☐ Separated	
☐ Yes ☐ No	who has served in the United States military?	of Aging transmitting my name, email address, mailing address, and	Care Single (never m	narried)	
Declined / not	Officed States fillillary:	mobile telephone number to the	Receiver	uto.	
stated	Yes	Department of Veterans Affairs only	Decimed to other	ico .	
	☐ No ☐Declined / not	for the purpose of receiving additional information on veterans			
	stated	benefits for which I may be eligible.			
		understand that this consent is valid			
		for12 months."			
		☐ Yes ☐ No			
		Contact the California Department			
		of Veterans Affairs (CalVet) to			
		determine eligibility for services and supports www.calvet.ca.gov			
		or 1-800-952-5626.			

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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:	IADLs:
Bathing	Heavy Hous
Dressing	Light House
Eating	Meal Prepa
Toileting	Medication
Transferring In / Out of Bed / Chair	Money Man
Walking	Shopping
Notes:	Transportat
	Using Telep
	Notes:

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

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