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
### SECTION 3 — FCSP Caregiver Information

<table>
<thead>
<tr>
<th>Caregiver Personal Data (Please Print):</th>
<th></th>
<th>Unique Participant ID:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Middle Initial:</td>
<td>Above FPL</td>
<td>At or below FPL</td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
<td>$ 1,215 or less per month-1 person</td>
<td></td>
</tr>
<tr>
<td>Birth Date:</td>
<td></td>
<td>$ 1,643 or less per month-2 persons</td>
<td></td>
</tr>
<tr>
<td>Home Phone #:</td>
<td>( )</td>
<td>Lives Alone:</td>
<td>No</td>
</tr>
<tr>
<td>What is your gender: (Check only one)</td>
<td>a. Male</td>
<td>Rural:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>b. Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Transgender Female to Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Transgender Male to Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Genderqueer / Gender Non-binary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Not listed, please specify: ___________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>g. Declined / not stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was your sex at birth: (Check only one)</td>
<td>a. Male</td>
<td>Rural Area in San Mateo County</td>
<td>94018 El Granada &amp; Princeton-by-the-Sea</td>
</tr>
<tr>
<td></td>
<td>b. Female</td>
<td>94019 Half Moon Bay</td>
<td>94038 Moss Beach</td>
</tr>
<tr>
<td></td>
<td>c. Declined / not stated</td>
<td>94020 La Honda</td>
<td>94060 Pescadero</td>
</tr>
<tr>
<td>How do you describe your sexual orientation or sexual identity: (Check only one)</td>
<td>a. Straight / Heterosexual</td>
<td>94021 Loma Mar</td>
<td>94074 San Gregorio</td>
</tr>
<tr>
<td></td>
<td>b. Bisexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Gay / Lesbian/Same-Gender Loving</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Questioning / Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Not listed, please specify: ___________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>f. Declined / not stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Address:</td>
<td></td>
<td>Ethnicity:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
<td>Race: (Check only one)</td>
<td>American Indian / Alaska Native</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple Race</td>
<td>Other Race</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asian:</td>
<td>Asian Indian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Filipino</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Laotian</td>
<td>Other Asian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hawaiian/Other Pacific Islander:</td>
<td>Guamanian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Pacific Islander</td>
<td>Samoan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Declined to State</td>
<td></td>
</tr>
</tbody>
</table>

### Care Receiver

- Care Receiver _______________________________
- Relationship Status of Care Giver
  - Relationship to Care Receiver: Daughter / Daughter- in-law
  - Domestic Partner
  - Grandparent
  - Husband
  - Non-Relative
  - Other Relative
  - Son / Son-in-law
  - Wife
  - Declined to State
- Employment Status of Caregiver
  - Full Time
  - Part Time
  - Retired
  - Unemployed
  - Declined to State

Have you ever served in the United States military?
- Yes
- No
- Declined / not stated

Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military?
- Yes
- No
- Declined / not stated

If you identify as being military affiliated, check below if: “I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 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.

Revised 06.2023
**SECTION 4 — FCSP Care Receiver Information**

*Please complete a separate form for each care receiver*

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>Birth Date:</td>
<td></td>
</tr>
<tr>
<td>Home Phone #:</td>
<td>( )</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>City:</th>
<th>Zip Code:</th>
</tr>
</thead>
</table>

**Federal Poverty Level (FPL):**
- $ 1,215 or less per month-1 person
- $ 1,643 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

**Have you ever served in the United States military?**
- □ Yes
- □ No
- □ Declined / not stated

**Are you the spouse, legal partner, parent, or child of a person who has served in the United States military?**
- □ Yes
- □ No
- □ Declined / not stated

If you identify as being military affiliated, check below if: “I consent to this agency and the California Department of Aging transmitting my name, email address, mailing address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months.”
- □ Yes
- □ No

Contact the California Department of Veterans Affairs (Cal Vet) to determine eligibility for services and supports www.calvet.ca.gov or 1-800-952-5626.

**Care Giver**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Status of the Care</th>
<th>Status of the Receiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Divorced</td>
<td>□ Single (never married)</td>
<td>□ Widowed</td>
</tr>
<tr>
<td>□ Domestic Partner</td>
<td>□ Married</td>
<td>□ Declined to State</td>
</tr>
<tr>
<td>□ Married</td>
<td>□ Separated</td>
<td>□ Declined to State</td>
</tr>
<tr>
<td>□ Separated</td>
<td>□ Single</td>
<td>□ Declined to State</td>
</tr>
</tbody>
</table>

**Unique Participant ID:** ____________________________
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

<table>
<thead>
<tr>
<th>ADLs:</th>
<th>IADLs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Heavy Housework</td>
</tr>
<tr>
<td>Dressing</td>
<td>Light Housework</td>
</tr>
<tr>
<td>Eating</td>
<td>Meal Preparation</td>
</tr>
<tr>
<td>Toileting</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Transferring In / Out of Bed / Chair</td>
<td>Money Management</td>
</tr>
<tr>
<td>Walking</td>
<td>Shopping</td>
</tr>
<tr>
<td>Notes:</td>
<td>Transportation</td>
</tr>
<tr>
<td></td>
<td>Using Telephone</td>
</tr>
</tbody>
</table>

Notes: