**SECTION 1 – Service Information**

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Registration / Assessment Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Termination Date:</td>
</tr>
<tr>
<td></td>
<td>Reason:</td>
</tr>
</tbody>
</table>

**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>Unique Participant ID:</th>
<th>Federal Poverty Level (FPL):</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name: __________________________</td>
<td></td>
<td>Above FPL</td>
</tr>
<tr>
<td>Last Name: ___________________________</td>
<td></td>
<td>At or below FPL</td>
</tr>
<tr>
<td>Birth Date: __________________________</td>
<td></td>
<td>Declined to State</td>
</tr>
<tr>
<td>Home Phone #: ( )______________________</td>
<td></td>
<td>Lives Alone:</td>
</tr>
<tr>
<td>What is your gender?</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>(Check only one)</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>a. Male</td>
<td></td>
<td>Declined to State</td>
</tr>
<tr>
<td>b. Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Transgender Female to Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Transgender Male to Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Genderqueer / Gender Non-binary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Not listed, please specify: ________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Declined / not stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was your sex at birth?</td>
<td></td>
<td>Rural:</td>
</tr>
<tr>
<td>(Check only one)</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>a. Male</td>
<td></td>
<td>Declined to State</td>
</tr>
<tr>
<td>b. Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Declined / not stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do you describe your sexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>orientation or sexual identity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Check only one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Straight / Heterosexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Bisexual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Gay / Lesbian/Same-Gender Loving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Questioning / Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Not listed, please specify: ________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Declined / not stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip Code: ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Receiver</th>
<th>Care Receiver</th>
<th>Care Receiver</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship to Care Receiver:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter / Daughter-in-law</td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td></td>
</tr>
<tr>
<td>Non-Relative</td>
<td></td>
</tr>
<tr>
<td>Other Relative</td>
<td></td>
</tr>
<tr>
<td>Son / Son-in-law</td>
<td></td>
</tr>
<tr>
<td>Wife</td>
<td></td>
</tr>
<tr>
<td>Brother / Sister</td>
<td></td>
</tr>
<tr>
<td>Declined to State</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship Status of Care Giver</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td></td>
</tr>
<tr>
<td>Single (never married)</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td></td>
</tr>
<tr>
<td>Declined to State</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status of Caregiver</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Time</td>
<td></td>
</tr>
<tr>
<td>Part Time</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
</tr>
<tr>
<td>Declined to State</td>
<td></td>
</tr>
</tbody>
</table>
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></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Check only one)</td>
</tr>
<tr>
<td>a. Male</td>
</tr>
<tr>
<td>b. Female</td>
</tr>
<tr>
<td>c. Transgender Female to Male</td>
</tr>
<tr>
<td>d. Transgender Male to Female</td>
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<tr>
<td>e. Genderqueer / Gender Non-binary</td>
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<tr>
<td>f. Not listed, please specify: __________</td>
</tr>
<tr>
<td>g. Declined / not stated</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What was your sex at birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Check only one)</td>
</tr>
<tr>
<td>a. Male</td>
</tr>
<tr>
<td>b. Female</td>
</tr>
<tr>
<td>c. Declined / not stated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do you describe your sexual orientation or sexual identity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Check only one)</td>
</tr>
<tr>
<td>a. Straight / Heterosexual</td>
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<tr>
<td>b. Bisexual</td>
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<tr>
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<tr>
<td>d. Questioning / Unsure</td>
</tr>
<tr>
<td>e. Not listed, please specify: __________</td>
</tr>
<tr>
<td>f. Declined / not stated</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Residential Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Zip Code:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Unique Participant ID: ________________________</th>
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</table>

<table>
<thead>
<tr>
<th>Federal Poverty Level (FPL):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above FPL</td>
</tr>
<tr>
<td>At or below FPL</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lives Alone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rural Areas in San Mateo County</th>
</tr>
</thead>
<tbody>
<tr>
<td>94018 El Granada &amp; Princeton-by-the-Sea</td>
</tr>
<tr>
<td>94019 Half Moon Bay</td>
</tr>
<tr>
<td>94020 La Honda</td>
</tr>
<tr>
<td>94021 Loma Mar</td>
</tr>
<tr>
<td>94037 Montara</td>
</tr>
<tr>
<td>94038 Moss Beach</td>
</tr>
<tr>
<td>94060 Pescadero</td>
</tr>
<tr>
<td>94074 San Gregorio</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
</tr>
<tr>
<td>Not Hispanic/Latino</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race: (Check all that applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian / Alaska Native</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>White</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asian:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Indian</td>
</tr>
<tr>
<td>Cambodian</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>Filipino</td>
</tr>
<tr>
<td>Japanese</td>
</tr>
<tr>
<td>Korean</td>
</tr>
<tr>
<td>Laotian</td>
</tr>
<tr>
<td>Other Asian</td>
</tr>
<tr>
<td>Vietnamese</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hawaiian/Other Pacific Islander:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guamanian</td>
</tr>
<tr>
<td>Hawaiian</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
</tr>
<tr>
<td>Samoan</td>
</tr>
<tr>
<td>Tongan</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Giver:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
</tr>
<tr>
<td>Domestic Partner</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Status of the Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Separated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Receiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single (never married)</td>
</tr>
<tr>
<td>Widowed</td>
</tr>
<tr>
<td>Declined to State</td>
</tr>
</tbody>
</table>

Revised 02.2022
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>
<tr>
<td></td>
<td>Notes:</td>
</tr>
</tbody>
</table>

Notes: