

## NFCSP Caregiver Registration Form

<b>Name</b> (First, MI, Last):		<b>Date of Registration:</b>										
<b>Residential Address</b> (Fire No. & Street):		<b>Date of Birth</b> (month/day/year): / /										
<b>City/State/Zip:</b>		<b>Phone Number</b> (with area code):										
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Unspecified <input type="checkbox"/> Gender Nonconforming <input type="checkbox"/> Gender Fluid/Not Exclusively Male or Female <input type="checkbox"/> Self-Describe (specify) _____	<b>Race:</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____ ----- <b>Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<b>Household:</b> <input type="checkbox"/> I live alone. <input type="checkbox"/> I live with others. ----- <b>Income Status:</b> Is your income at or below the following guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"># in Home</th> <th style="text-align: left;">Month / Year</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>\$1,133 \$13,590</td> </tr> <tr> <td>2</td> <td>\$1,526 \$18,310</td> </tr> <tr> <td>3</td> <td>\$1,919 \$23,030</td> </tr> <tr> <td>4</td> <td>\$2,313 \$27,750</td> </tr> </tbody> </table>	# in Home	Month / Year	1	\$1,133 \$13,590	2	\$1,526 \$18,310	3	\$1,919 \$23,030	4	\$2,313 \$27,750
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<b>Name of the person you are caring for</b> (First, MI, Last):	
<b>What is the person's date of birth</b> (month/day/year)?                    /                    /	
<b>Caregivers of Older Adults</b>	<b>Older Relative Caregivers</b>
<b>What is your relationship to the person you are caring for?</b> <input type="checkbox"/> Husband <input type="checkbox"/> Wife <input type="checkbox"/> Son/Son-in-Law <input type="checkbox"/> Daughter/Daughter-in-Law <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative	<b>What is your relationship to the person you are caring for?</b> <input type="checkbox"/> Grandparent <input type="checkbox"/> Parent <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative
<b>If the person you care for is age 18-59, does the person have early onset dementia?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If the person you care for is age 18-59, does the person have a disability?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**PLEASE SEE OTHER SIDE**

Care Recipient Only – if receiving Respite Care or Supplemental Services:

<b>Activities of Daily Living (ADLs)</b> Check <b>Yes</b> for each ADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check <b>No</b> for each ADL you <i>can</i> complete without substantial assistance.	<b>No Help Needed</b>	<b>Yes, Needs Help</b>
<b>Bathing:</b> Gets in and out of the bath or shower, uses faucets, washes, and dries oneself safely.		
<b>Dressing:</b> Dresses and undresses safely.		
<b>Toileting:</b> Uses toilet and cleans oneself.		
<b>Transferring:</b> Moves in and out of bed or chair.		
<b>Feeding:</b> Gets food or drink from plate, bowl, or cup into mouth and uses utensils.		
<b>Continence:</b> Exercises complete self-control.		

**TOTAL Number of Yes ADLs** \_\_\_\_\_

<b>Instrumental Activities of Daily Living (IADLs)</b> Check <b>Yes</b> for each IADL that you/the client <i>need substantial assistance</i> to complete (including verbal reminding, physical cuing, or supervision). Check <b>No</b> for each IADL you <i>can</i> complete without substantial assistance.	<b>No Help Needed</b>	<b>Yes, Needs Help</b>
<b>Food Preparation:</b> Plans, prepares, and serves adequate meals independently.		
<b>Shopping:</b> Takes care of all shopping needs independently.		
<b>Medication Management:</b> Takes medication in correct dosages at correct time.		
<b>Ability to Manage Finances:</b> Handles financial matters and/or day-to-day purchases.		
<b>Housekeeping:</b> Participates in housekeeping tasks.		
<b>Laundry:</b> Launders some items independently.		
<b>Mode of Transportation:</b> Travels unassisted via personal vehicle, public transportation, or taxi.		
<b>Ability to Use Telephone:</b> Dials and/or answers the telephone.		

**TOTAL Number of Yes IADLs** \_\_\_\_\_

Additional Care Recipient information (optional):

<b>Telephone Number:</b>
<b>Residential Address (Fire No. &amp; Street):</b>
<b>City/State/Zip:</b>

Privacy Statement: "The information you are being asked to provide is needed to determine if you are eligible to receive Older Americans Act Services and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this, please ask the aging unit staff."