NFCSP Caregiver Registration Form

Name (First, MI, Last):	**Date of Registration:**
Residential Address (Fire No. & Street):	**Date of Birth** (month/day/year)**:** / /
City/State/Zip:	**Phone Number** (with area code)**:**

Gender Identity:
- ❒ Male
- ❒ Female
- ❒ Transgender Male
- ❒ Transgender Female
- ❒ Self-Describe (specify): _____

Preferred Language:
- ❒ English
- ❒ Spanish
- ❒ Hmong
- ❒ Other: _____

Race:
- ❒ American Indian or Alaska Native
- ❒ Asian or Asian American
- ❒ Black or African American
- ❒ Native Hawaiian or Pacific Islander
- ❒ White
- ❒ Other _____

Ethnicity:
- ❒ Hispanic or Latino
- ❒ Not Hispanic or Latino

Household:
- ❒ I live alone.
- ❒ I live with others.

Income Status:

Is your income at or below the following guidelines?

❒ Yes ❒ No

# in Home	Month	Year
1	$1,215	$14,580
2	$1,643	$19,720
3	$2,072	$24,860
4	$2,500	$30,000

Name of the person you are caring for (First, MI, Last)**:**

What is the person's date of birth (month/day/year)**?** / /

Caregivers of Older Adults	**Older Relative Caregivers**
What is your relationship to the person you are caring for? ❒ Husband ❒ Wife ❒ Son/Son-in-Law ❒ Daughter/Daughter-in-Law ❒ Sister ❒ Brother ❒ Other Relative ❒ Non-Relative	**What is your relationship to the person you are caring for?** ❒ Grandparent ❒ Parent ❒ Other Relative ❒ Non-Relative
If the person you care for is age 18-59, does the person have early onset dementia? ❒ Yes ❒ No	**If the person you care for is age 18-59, does the person have a disability?** ❒ Yes ❒ No

PLEASE SEE OTHER SIDE

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

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

TOTAL Number of Yes ADLs _____

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

TOTAL Number of Yes IADLs _____

Additional Care Recipient information (optional):

Telephone Number:
Residential Address (Fire No. & Street):
City/State/Zip:

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."