CAREGIVER SELF ASSESSMENT

EMPLOYMENT

1. Because of the time I spend taking caring of someone else, I have: ***(Check all that apply)***

a. ☐ Stopped working
b. ☐ Retired early
c. ☐ Taken a less demanding job
d. ☐ Changed from full time to part-time work
e. ☐ Loss of some fringe benefits
f. ☐ Time conflicts between work and Caregiver
g. ☐ Used vacation time to provide care
h. ☐ Taken leave of absence to provide care
i. ☐ Lost a promotion
j. ☐ Taken off work early or got to work late
k. ☐ Other
l. ☐ None

SOCIAL SUPPORTS

1. Of the programs listed, I am receiving the following services or would like to apply for these services? Put a C in the box if you receive this service or an R if the person you are caring for receives this service.

	Yes	No	Want to Apply		Yes	No	Want To Apply
a. Homemaker Program	☐	☐	☐	n. Food Stamps	☐	☐	☐
b. Private Pay cleaning	☐	☐	☐	o. Adult Day Care	☐	☐	☐
c. Attendant Serv Prog	☐	☐	☐	p. Rx Access	☐	☐	☐
d. Medicare Home Health	☐	☐	☐	q. SHIINE	☐	☐	☐
e. Private Pay Nursing	☐	☐	☐	r. Fuel Assistance	☐	☐	☐
f. Speech Therapy	☐	☐	☐	s. Chore Services	☐	☐	☐
g. Occupational Therapy	☐	☐	☐	t. Respite Care	☐	☐	☐
h. Physical Therapy	☐	☐	☐	u. Low income housing	☐	☐	☐
i. Weatherization	☐	☐	☐	v. Grocery delivery	☐	☐	☐
j. Emergency Response	☐	☐	☐	w.Transportation	☐	☐	☐
k. Senior Companion	☐	☐	☐	x. Other(list)	☐	☐	☐
l. Home Deliv Meals	☐	☐	☐	y.	☐	☐	☐
m.Congregate Meals	☐	☐	☐	z.	☐	☐	☐

CARE

	I provide the following assisstance			Need Help to Provide Care	I need the following assistance		
	Total	Some	None		Total	Some	None
Eating:							
Dressing:							
Bathing:							
Toileting:							
Transfer:							
Walking:							
Meal Preparation							
Shopping							
Medication Management							
Money Management:							
Light Household Cleaning							
Heavy Household Cleaning:							
Transportation							
Use of telephone							
Personal Hygiene:							
Laundry							
Home Maintenance							

ADAPTIVE DEVICES: **N = Item is <u>NEEDED</u>**
H = Have the item

	Cane		Wheelchair		Bathseat/transfer bench
	Walker		Braces		Protective restraints
	Crutches		Dressing aids		TAD (special phone)
	Prosthesis		Bed rails		Emergency Response
	Reacher		Hospital Bed		Medication Mgmt. Device
	Elevated toilet seat		Electric chair lift		Handheld Shower
	Grab rails/bars		Commode		Other

CARE - *CONTINUED*

How often does providing Care:	Never	Rarely	Some	Quite Frequently	Nearly Always
Create a financial burden?					
Leave me with not enough time for myself?					
Leave me with not enough time for my family.					
Interfere with my job?					
Affect relationships with my family in a negative way?					
Interferes with my personal need for privacy?					
Create problems in my social life?					
Create stress?					

ASA SERVICE RELATED QUESTIONS

CAREGIVER RELIEF	Yes	No	Frequency	Need More Assistance
1. Do other **family members** provide care so that I may have a break or leave the home?	☐	☐		☐
2. Do **friends** provide care so that I may leave my home or have a break?	☐	☐		☐
3. Is there another agency or provider who can offer relief?	☐	☐		☐
4. Is this assistance available on short notice?	☐	☐		☐

THOUGHTS:

COUNSELING/SUPPORT GROUPS	Yes	No	Frequency	Need Assistance
1. I am experiencing emotional concerns or difficulties?				
2. I have had trouble falling asleep or staying asleep?				
3. I am lonely?				
4. I have been edgy or irritable?				
5. I have had crying spell(s)				
6. I have felt strained between work and family responsibilities?				
7. My family has trouble coordinating and agreeing on the care?				
8. I have been so upset that I did something to my relative or friend that I now regret?				
9. My relative or friend has done things to hurt me?				
10. I participate in a support group or discussion group where I can discuss my feelings?				
TRAINING	**Yes**	**No**	**Explain**	
1. I have trouble understanding the behaviors of the person I am caring for?				
2. I need training on how to work with the person I am caring for when they become confused?				
3. I need training on lifting and transferring the person I am caring for?				
4. I need training to better understand the diagnosis of the person I am caring for and how to manage this diagnosis through Nutritional Needs, Feeding, OT, PT, Nursing, Speech Therapy or Communication Skills?				

THOUGHTS:

Supplemental Services	Yes	No	Explain
1. I have trouble finding time to prepare meals?			
2. I have trouble doing outside chores?			
3. I would benefit from having a Home Safety Evaluation?			
4. I would benefit from having someone evaluate the person I am caring for to identify items to assist me in providing care?			
5. I need assistance to transport the person I am caring for to the clinic?			
6. Transportation is difficult because of getting the person I am caring for into and out of the house, automobile, etc.?			
7. Transportation is difficult because of the distance to the services?			
8. I need someone to assist me with bathing, transferring or feeding the person I care for?			

THOUGHTS:_____

HOME ENVIRONMENT

	Yes	Comments:
a. Dangerous stairs/floors		
b. Difficult to get to home entrance		
c. Difficult to get to bathroom/bedroom		
d. Major appliances not working		
e. Problems with heating/cooling		
f. Utilities Shut off		
g. Difficult to keep home free of odors/pests		
h. Smoke alarm needed		
i. Electrical hazards		
j. Poor lighting		
k. Unsafe stove		
l. Loose/slippery rugs		
m. Inadequate locks for doors/windows		
n. Difficult to keep home clean		
o. Unable to do lawn care/snow removal		
p. Plumbing/toilet problems		
q. Problems with neighbors/neighborhood		
r. Problems with garbage/spoiled food		
s. Pets (too many/vicious)		
t. Evidence of hoarding		
u. Other problems(describe)		