OFFICE USE ONLY

Program___________________________
Date______________________________
Code______________________________
Results #___________________________
Member ___________**Yes** ___________ **No**

RESPITE CARE ASSISTANCE PROGRAM – FY'12

Caregiver Section:

Primary Caregiver Living with Person with Dementia (PWD)_______________________________________

Relationship to person with dementia____

Birthdate of Caregiver__________________________E-mail address_______________________________________

Address_______________________________________City_____________________State_________Zip__________

County: ____________________________Phone: Home: Area Code (   ) ___________________________________

Work: Area Code (   )______________________Cell or alternate number: Area Code (   )____________________

Would you like to be called at: ☐ Home ☐ Work If at Work, hours to be called:__________________________________

Do you work full-time or part-time? ☐ No ☐ Full-time ☐ Part-time Work hours: __________________________

Caregiver's health: ☐ Excellent ☐ Good ☐ Fair: Please explain:______________________ ☐ Poor: Please explain:

___________________________________How long have you been providing care? _____________________________

How long have you been living together?____
Referred to Respite program by:____

Care Receiver Section:

Person with Dementia's (PWD) Name____Sex_____________

Date of Birth ____________________________SS# ____

Emergency Contact: other than the caregiver:

1) Name ____ Relationship:______________ Phone________________
2) Name ____ Relationship:______________ Phone________________

Doctor ____ Phone__________________

List below all other members living in the household. PLEASE LIST ADDITIONAL NAMES ON THE BACK OF THIS PAGE.

1.Name_____________________________Relationship to person with dementia: _______________Age: __________
Does this person ☐ help with caregiving ☐ requires care
2. Name ____________________________Relationship to person with dementia: _______________Age: __________
Does this person ☐ help with caregiving ☐ requires care
3. Name ____________________________Relationship to person with dementia: _______________ Age: _________
Does this person ☐ help with caregiving ☐ requires care

Please complete the following questions to help us determine your caregiving needs.

Which of the following services is the **Person with Dementia** presently receiving?

a) (Check **ALL** services the person is receiving.) **Do not include services provided by those living in the household.**

TOTAL HOURS PER WEEK	SERVICE	TOTAL HOURS PER WEEK	SERVICE
_____	Unpaid/volunteer help from family, friends and others outside the home	_____	Case management
_____	Paid companion	_____	Transportation services
_____	Homemaker/Chore services	_____	Psychological counseling
_____	Personal care services	_____	Group meals/home delivered meals
_____	Home health services (nursing)	_____	Other services, list below:
_____	Adult daycare center/adult day health	_____	
_____	Respite care given in a facility, or someone else's home.	_____	

b) How are these services paid for? (check all that apply)

☐	Private Pay	☐	Medicare	☐	Long Term Care Insurance
☐	Medicaid/Division of Health & Senior Services(red card)	☐	Area Agency on Aging	☐	PACE
☐	Parkinson's Association	☐	Hospice	☐	Other(specify)

c) Is the PWD approved for Medicaid?

☐ Has applied ☐ Yes **IF YES, provide DCN#** __________________ ☐ No

How would you rate your current level of stress? ☐ Very high ☐ High ☐ Moderate ☐ Low ☐Very low

Please complete the following checklist according to the person with dementia's **(PWD)** ability to perform these activities: (**Please check all that apply.**) When answering **"Who helps with this activity?"** list all persons who help, i.e. yourself, other family members, friends, home health agency worker, etc.

Eating

1. Feeds self except for minor assistance with cutting meat, etc. ☐
2. Feeds self with moderate assistance and is untidy ☐
3. Tube fed, difficulty swallowing, or does not feed self at all ☐

Who helps with this activity?________________________________

Dressing

1. Dresses, undresses, and selects clothing ☐
2. Needs some help with getting out clothes, dressing, including undergarments and fastening, undressing ☐
3. Needs complete assistance with dressing ☐

Who helps with this activity? ________________________________

Bathing

1. Needs no assistance; gets in/out of bath/shower by self ☐
2. Needs help getting in/out of bath/shower and minimal supervision ☐
3. Needs total assistance ☐

Who helps with this activity? ________________________________

Toileting

1. Gets to toilet; gets on and off toilet and cleans self ☐
2. Needs to be reminded or needs help in cleaning self; rare accidents ☐
3. Cannot control bladder and/or bowels (**circle 1 or both)** ☐

Who helps with this activity? ________________________________

Transferring

1. Able to get in & out of bed and in & out of chair independently ☐
2. Needs assistance in getting in & out of bed and in & out of chair ☐
3. Needs total assistance and/or is bedbound ☐

Who helps with this activity? ________________________________

Walking

1. Independent or uses walker or cane with no assistance needed ☐
2. Gets around with assistance of a) another person ____, b) railing ____, c) cane ____, d) walker____, e) wheelchair____. ☐
3. Bedridden more than half of the time ☐

Who helps with this activity?________________________________

Wandering

1. Never has wandered ☐
2. Occasionally attempts to or successfully wanders ☐
3. Frequently attempts to or successfully wanders ☐

Who monitors this activity? ______________________________

Is individual registered in the Safe Return Program? ☐Yes ☐ No

Sleeping

1. Sleeps through the night ☐
2. Awakes and/or is up occasionally at night ☐
3. Awakes and/or is up frequently at night ☐

Who monitors this activity? ______________________________

SPECIAL NEEDS:	Caregiver	PWD
On oxygen?	☐	☐
Other: explain________________	☐	☐

Please complete this checklist according to the **person with dementia's (PWD)** ability to perform these activities: (Check category that most applies)

	How often does PERSON WITH DEMENTIA (PWD) need help with these activities?	**Needs No Help (No Supervision)**	**Needs Some Help (Occasional Supervision)**	**Needs a Lot of Help (Constant Supervision)**	**Doesn't/can't peform task at all**
(a)	**Preparing Meals** Who helps with this?				
(b)	**Shopping** Who helps with this?				
(c)	**Medication Management** Who helps with this?				
(d)	**Money Management** Who helps with this?				
(e)	**Telephone Use** Who helps with this?				
(f)	**Housework** Who helps with this?				

What are the most challenging aspects of caregiving?

____
____
____
____
____

Current Marital Status: (Check answer)

PWD : Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐

CAREGIVER: Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐

The following is ***OPTIONAL** information: **Race and income information will in no way affect program eligibility. This information will help us better serve you.**

*a. Which of the following categories best describes race: (Please check one(s) that apply)

CAREGIVER	**PWD**
☐ Caucasian	☐ Caucasian
☐ Black / African American	☐ Black / African American
☐ Hispanic / Latino	☐ Hispanic / Latino
☐ Native American Indian	☐ Native American Indian
☐ Asian	☐ Asian
☐ Native Hawaiian / Pacific Islander	☐ Native Hawaiian / Pacific Islander

*b. Which of these categories is closest to **PWD's** total annual income? (include ONLY the person with dementia's income)

☐	Under $9,257	☐	Not reported
☐	$9,257 – $10,890	☐	
☐	$10,890 - $20,147	☐	
☐	$20,417 and over	☐	

I understand the information to be correct as of ______________________________
(Date)

Signature of **primary caregiver living with person with dementia**

____

Complete and mail this form to:

Respite Care Assistance Program, Alzheimer's Association St. Louis Chapter

9370 Olive Blvd., St. Louis, MO 63132

Phone: 1.800.272.3900 Fax: 314.432.3824

Proud member of

United Way of Greater St. Louis