

**BLUEGRASS AREA AGENCY ON AGING
FAMILY CAREGIVER SUPPORT PROGRAM**

CAREGIVER SELF ASSESSMENT

Caregiver's Name: _____ Elder's Name(s): _____

Caregiver's Date of Birth: ___/___/___ Caregiver's Gender: **Male** **Female**
(Circle One)

Relationship to Elder: Husband/Wife _____
Daughter/Daughter-in-Law _____
Son/Son-in-Law _____
Brother/Sister _____
Grandson/Granddaughter _____
Other Relative _____
Non-Relative/Friend _____

Does caregiver work outside the home? Yes _____ No _____ Hours per week: _____

Do school-aged children or other dependents live at home? Yes _____ No _____

How do you rate your own health? Excellent _____ Good _____ Fair _____ Poor _____

Do you live with your elder or loved one? Yes _____ No _____

How long have you been a caregiver for this person? _____

How many hours per week do you spend caregiving? _____

What type of care do you help provide? Check all that apply.

Hygiene/Bathing/Toileting _____	Household Chores _____
Meal Preparation _____	Finance/Mail _____
Administration of Medication _____	Driving _____
Monitoring/Company Indoors _____	
Monitoring/Escort/Company Outdoors _____	

Of these activities, which have proved most difficult to manage? _____

What are/have been the consequences of your care responsibilities?

- Difficulties in getting out _____
- Difficulties in getting personal time for leisure _____
- Difficulties in meeting work or financial obligations _____
- Difficulties in finding help from other relatives _____
- Difficulties in finding help from public/social services _____
- Difficulties in other social/personal relationships _____

What kind of support do you receive from family or friends?

- Day-to-day care support _____
- Psychological support _____
- Information or decision-making support _____
- Temporary respite/sitter support _____
- Errands or household support _____
- Financial management support _____

In which of the following areas would you like more resource information:

- | | |
|---|-----------------------------------|
| In-Home Care _____ | Companionship _____ |
| Adult Day Care _____ | Volunteer Services _____ |
| Assisted Living Facilities _____ | Escort/Transportation _____ |
| Group Homes _____ | Prescription Assistance _____ |
| Long Term Care/Nursing Facilities _____ | Senior Center Services _____ |
| Home Delivered Meals _____ | Chronic or Acquired Disease _____ |
| Health Programs _____ | Medicare/Medicaid _____ |
| Social Security _____ | Advocacy _____ |
| Legal Issues _____ | Hospice/End of Life _____ |
| Support Groups _____ | Case Management _____ |
| Elder Abuse or Neglect _____ | Elder Driving Safety _____ |
| Long Distance Caregiving _____ | Caregiver Training _____ |
| Health Care Equipment /Supplies _____ | Home Repair _____ |
| Other _____ - - Please Specify: _____ | |

Please add anything else here that you think is important for us to know about you and your caregiving situation:
