

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

ENROLLMENT FORM

Date: ____/____/____

Caregiver's Name: _____ **County of Residence:** _____

Birthdate: ____/____/____ **Age:** ____ **SSN#:** ____-____-____

Gender: Male or Female
(Circle One)

Locality: Rural or Non-Rural
(Circle One)

Relationship to Person Being Cared For:

Husband ____ Wife ____ Son/Son-in-Law ____ Daughter/Daughter-in-Law ____

Grandparent ____ Other Relative ____ Friend ____ Neighbor ____

Other Non-Relative ____

Ethnicity: Hispanic or Latino ____ Not Hispanic or Latino ____

Race: White (Non-Hispanic) ____ White (Hispanic) ____ Asian ____

American Indian/Alaska Native ____ Black/African America ____

Native Hawaiian/Pacific Islander ____ Two or More Races ____

Other ____

The information requested on this form is used for mandated State and Federal Reporting purposes only. No information contained herein will be used in making a determination of program or service eligibility, nor will it be shared with outside agents or agencies, apart from communication necessary to facilitate service delivery.