

**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.*