

STATE OF DELAWARE  
DIVISION OF SERVICES FOR AGING AND ADULTS WITH PHYSICAL DISABILITIES

**ATTACHMENT A**

	<b>Intake Assessment Form CF-044</b>
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Date of Assessment:
CRC Coordinator Name:

*Please fill in all information, as it is required for federal data reporting.*

<b>CAREGIVER INFORMATION</b>	
First Name:	Last Name:
Preferred Name:	
Preferred Pronouns:	<input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other:

Address:	Apt #:	County: <input type="checkbox"/> NCC <input type="checkbox"/> Kent <input type="checkbox"/> Sussex
Address 2 (Apt. Complex Name or Development Name):		
City:	State:	Zip:
Telephone 1:	Telephone 2:	
Email Address:		

Date of Birth (DOB):	<input type="checkbox"/> Not Reported
If DOB is unable to be collected, please check appropriate age range: <input type="checkbox"/> <50 <input type="checkbox"/> 50-59 <input type="checkbox"/> 60-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75-84 <input type="checkbox"/> 85+	

Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino	
Race:	<input type="checkbox"/> White – Non-Hispanic	
	<input type="checkbox"/> White – Hispanic	
	<input type="checkbox"/> American Indian/Alaska Native	
	<input type="checkbox"/> Asian	
	<input type="checkbox"/> Black or African American	
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
	<input type="checkbox"/> Other Race	
Reporting 2 or More Races:	<input type="checkbox"/> YES	
Race Data Missing:	<input type="checkbox"/> YES	

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Are you the PRINCIPAL CAREGIVER? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the care recipient live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Care Recipients Name:
Relationship to Care Recipient: <input type="checkbox"/> Husband <span style="margin-left: 200px;"><input type="checkbox"/> Other Relative</span> <input type="checkbox"/> Wife <span style="margin-left: 200px;"><input type="checkbox"/> Non-Relative</span> <input type="checkbox"/> Son/Son-in-Law <span style="margin-left: 200px;"><input type="checkbox"/> Relationship Not Reported</span> <input type="checkbox"/> Daughter/Daughter-in-Law
Does the Care Recipient have Alzheimer's Disease or Related Dementia Diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you also care for children under 18 living at home? <input type="checkbox"/> Yes <input type="checkbox"/> No

Employment Status	<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Not Employed
Does caregiving impact your employment status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes

How does caregiving impact your employment status?

If you are currently unemployed or underemployed, do you want to work?  
 Yes  No  Full-Time  Part-Time

On average, how many weekly hours of care do you provide?	<input type="checkbox"/> Less than 10	<input type="checkbox"/> 11 -20	<input type="checkbox"/> 21 - 30	<input type="checkbox"/> 30+
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Self-Reported Caregiver Burden Scale	<input type="checkbox"/> 1 (Very Little Burden/Stress) <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (High Burden/Stress)
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What services, supports or needs is the caregiver reporting/requesting?	
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Identify supportive services that are recommended to this Caregiver based on their needs:	<input type="checkbox"/> Caregiver Skills Training <input type="checkbox"/> Adult Day Program <input type="checkbox"/> In-Home Respite <input type="checkbox"/> ERS Services <input type="checkbox"/> Counseling <input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Home Modification <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Support Group <input type="checkbox"/> Dementia Education/Support <input type="checkbox"/> Transportation <input type="checkbox"/> Other:
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Caregiver was given the following information/publications:		
<input type="checkbox"/> ADRC Brochure	<input type="checkbox"/> CRC Flyer/Brochure	<input type="checkbox"/> DSAAPD Guide to Services
<input type="checkbox"/> Other:		

<b>CARE RECIPIENT INFORMATION</b>	
First Name:	Last Name:
Preferred Name:	
Preferred Pronouns:	<input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other:

Check if same address as Caregiver <input type="checkbox"/>		
Address:	Apt #:	County: <input type="checkbox"/> NCC <input type="checkbox"/> Kent <input type="checkbox"/> Sussex
Address 2 (Apt. Complex Name or Development Name):		
City:	State:	Zip:
Telephone 1:		
Email Address:		

Date of Birth (DOB):	<input type="checkbox"/> Not Reported
If DOB is unable to be collected, please check appropriate age range: <input type="checkbox"/> <50 <input type="checkbox"/> 50-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60-74 <input type="checkbox"/> 75-84 <input type="checkbox"/> 85+	

Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino	
Race:	<input type="checkbox"/> White – Non-Hispanic	
	<input type="checkbox"/> White – Hispanic	
	<input type="checkbox"/> American Indian/Alaska Native	
	<input type="checkbox"/> Asian	
	<input type="checkbox"/> Black or African American	
	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
	<input type="checkbox"/> Other Race	
Reporting 2 or More Races:	<input type="checkbox"/> YES	
Race Data Missing:	<input type="checkbox"/> YES	

Does the Care Recipient have a PRINCIPAL CAREGIVER? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the care recipient live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, how many in household?

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Caregiver's Name: \_\_\_\_\_

<p>How many of the following 6 ADL's is the care recipient <b>UNABLE</b> to perform without personal assistance, standby assistance, supervision, or cues?</p>	<input type="checkbox"/> Dressing <input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Transferring in/out of bed/chair <input type="checkbox"/> Eating <input type="checkbox"/> Walking	<p>Total Care Recipient ADL's</p> <p style="text-align: center;"><input type="checkbox"/> 0   <input type="checkbox"/> 1   <input type="checkbox"/> 2   <input type="checkbox"/> 3+</p>
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<p>How many of the following 8 IADL's is the care recipient <b>UNABLE</b> to perform without personal assistance, standby assistance, supervision, or cues?</p>	<input type="checkbox"/> Preparing Meals <input type="checkbox"/> Medication Management <input type="checkbox"/> Money Management <input type="checkbox"/> Using the Telephone <input type="checkbox"/> Doing Heavy Housework	<input type="checkbox"/> Doing Light Housework <input type="checkbox"/> Access Transportation <input type="checkbox"/> <input type="checkbox"/> Personal Shopping	<p>Total Care Recipient IADL's</p> <p style="text-align: center;"><input type="checkbox"/> 0   <input type="checkbox"/> 1   <input type="checkbox"/> 2   <input type="checkbox"/> 3+</p>
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<p>Services recommended to/for the care recipient are:</p>	<input type="checkbox"/> ADRC Referral <input type="checkbox"/> Personal Care <input type="checkbox"/> Adult Day Program <input type="checkbox"/> ERS Services <input type="checkbox"/> Meals <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Home Modification <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Support Group <input type="checkbox"/> Caregiver Resource Center <input type="checkbox"/> Transportation <input type="checkbox"/> Other:
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Notes: Click here to enter text.