SUBMITTING YOUR APPLICATION

Please return the completed application to:

Santee-Lynches Regional Council of Governments

Family Caregiver Support Program

39 E. Calhoun St. Sumter, SC 29150

Fax: *(803)774-1030*

CAREGIVER PARTICIPATION AGREEMENT

Caregiver's **or** Grandparent's Name: _____
(if applying for SRC program)
Care Receiver **or** Grandchild(ren) Name(s): _____

I certify that I am responsible for the care of the Care Receiver/Grandchild(ren), who lives in the Santee-Lynches Region (*Clarendon, Kershaw, Lee and Sumter Counties*), and I am the primary responsible person providing or directing his/her/their care.

1. I certify that all information provided to the Santee-Lynches Area Agency on Aging FCSP staff is correct to the best of my knowledge.
2. I understand that no one who lives in the household may receive FCSP funds or respite funds for providing services. I further understand that if I break this rule or provide incorrect or fraudulent information, or the misuse of funds, I may be permanently terminated from this program.
3. I understand that my participation in cost sharing is voluntary. My level of participation depends on my willingness and ability to share in the cost of the service.
4. I pledge to *promptly* (within 7 working days) notify the Caregiver Advocate of changes in situation (such as major health changes, hospitalization, change of address or phone number, change in condition of either the Care Receiver, grandchildren I am responsible for, or myself.
5. I am willing to abide by the guidelines of the FCSP, including making choices of providers and resources, following the required hiring procedures, completing monthly forms and sending them in for reimbursement *(within 30 days for date of service or purchase).*
6. I understand that the maximum amount of funds received in one calendar year will vary depending on available funding.
7. I understand that where applicable, submitted receipts must be approved by the Family Caregiver Support Coordinator prior to reimbursement. Failure to abide by program guidelines will disqualify me from reimbursement. I have been informed of my rights and responsibilities as a client in the FCSP.
8. I understand that the Santee-Lynches Area Agency on Aging FCSP and other respite programs is a Caregiver directed program and I will be requested to participate in interviews and/or surveys to measure client satisfaction and effectiveness of the program. I also understand that if I choose not to respond it will not to respond it will not affect my eligibility for the program and its benefits.
9. I understand that the Family Caregiver Coordinator or other Santee-Lynches staff reserve the right to conduct unannounced visit to validate eligibility.

Signature: _____ Date: _____
(Caregiver)

CONSENT TO RELEASE INFORMATION

(Family Caregiver)

Last Name: _____

First Name: _____

Middle Name: _____

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Lieutenant Governor's Office on Aging and the U.S. Federal Government. The information provided will be kept confidential and guarded against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for clients (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client).

My information may be used to arrange for these services: **Yes** ☐ **No** ☐

Some of the data asked for is required by either the South Carolina Lieutenant Governor's Office of Aging and/or the U.S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

My information may be shared with the entity(ies) funding my service(s): **Yes** ☐ **No** ☐

Client Signature: _____ Date: _____

If read to client, by whom: _____ Date: _____

Relation: _____

Assessor Signature: _____ Date: _____

Caregiver Assessment

Interviewer	Date

Caregiver Information

First Name	M.	Last Name

Physical Address / Mailing (if different)	Apt

City	State	Zip	Phone: Home • Mobile • Work
			( ) -

Phone: Home • Mobile • Work	Phone: Home • Mobile • Work	Email
( ) -	( ) -	

Age	DOB mm - dd - yyyy	ID Verified	County	Urban • Rural (circle)
		☐		

Reason for: Visit • Call (circle) Client: New • Current • Returning • Change in Status (circle)

Demographics

Gender
☐ Female ☐ Male ☐ Trans ☐ Declined

Hispanic, Latino, or Spanish origin (If yes, what ancestry?)
☐ No ☐ Yes _____ ☐ Declined

Marital Status
☐ Married (now) ☐ Never Married ☐ Widowed
☐ Divorced ☐ Separated ☐ Other
Name of Spouse: _____ ☐ Declined

Race
☐ White, Caucasian ☐ Black, African American
☐ American Indian / Alaskan ☐ Asian Indian
☐ Hawaiian / Pacific Islander ☐ Asian
☐ Other _____ ☐ Declined

Military Service (US Armed Forces, Reserves, or Ntl Gd)
☐ Never served ☐ Reserves ☐ Past Active Duty

Education
☐ No formal ☐ Some College (no degree)
☐ Grade 1 to 12 _____ ☐ Associate's degree
☐ HS Diploma ☐ Bachelor's degree
☐ GED ☐ Advanced degree _____
☐ Declined

Household Size and Income (refer to income table)
☐ < 100 % ☐ < 135 % ☐ Amount _____
☐ < 150 % ☐ < 175 % Actual people in Household _____
☐ < 200 % ☐ > 200 % LGOA adjusted Household size _____
☐ Declined Lives Alone? Yes • No

Languages Known

Does the CG speak a language other than English at home? ☐ Yes _____ ☐ No ☐ Declined

How well does the CG speak English? ☐ Very well ☐ Well ☐ Not well ☐ Not at all

Care Recipient Information

First Name	M.	Last Name	DOB mm - dd - yyyy

Care Recipient Condition

Does the care receiver have a condition that causes limitations in activities?

☐ Alzheimer's or related dementia ☐ Physical condition ☐ Other _____
☐ Intellectual disability (ID / DD) ☐ Cognitive / Behavioral condition ☐ No limiting condition

Has the care receiver been diagnosed, by a physician, to have Alzheimer's or a related dementia? Yes • No

Daily Living Assistance Support Provided

ADLs
☐ Bathing ☐ Walking / Mobility
☐ Dressing ☐ Eating
☐ Toileting
☐ Transfer

IADLs
☐ Meal Preparation ☐ Use of Telephone
☐ Laundry / Housekeeping ☐ Shopping
☐ Money Management ☐ Medication Mgmt
☐ Transportation

☐ Emotional support ☐ Social support ☐ Other

Care Recipient Information

Caregiver's Relationship to Care Recipient

☐ Spouse	☐ Parent	☐ Other relative, < 55	☐ Non-relative, < 55
☐ Child	☐ Grandparent	☐ Other relative, 55+	☐ Non-relative, 55 +
☐ Sibling	☐ Daughter/Son (in-law)		☐ Declined

Caregiver's Time

Are you a parent of a child(ren) under the age of 18? **Yes • No**	Are you caring for an adult(s) with a disability? **Yes • No**
Do you live with the recipient? **Yes • No**	If not, how far is it to the care recipient's home? _____ miles
How long does it take to travel there? ____ hours ____ minutes	
How long have you provided care for _____?	____ Years ____ Months
How often do you provide care for _____?	Daily • Weekly • Monthly
On average, how many hours do you spend providing care?	_____ hours per week
Are you paid to provide care? **Yes • No • Declined**	Other employment? **FT • PT • Not Employed • Declined**
Is there anyone else that provides care for _____?	**Yes • No • Declined**
Is there any other program that has provided respite services within the last twelve, (12) months?	**Yes • No**

Caregiver's Stress and Well Being

How do you rate your health? **Excellent • Above Avg • Average • Below Avg • Poor • Declined**

Check the response that best describes how you feel.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Declined**
I feel a sense of satisfaction helping _____.						
I am confident about providing care to _____.						
Caring for _____ is stressful.						
I feel a sense of obligation to provide care.						
My health has suffered because of my involvement providing care.						
My finances are strained because I provide care.						

Caregiver's Stress

What do you do to cope with the stress related to the challenges of caregiving?
Please elaborate.

Is this working to help relieve the stress?	Yes • Somewhat • No • NA • Declined
Have your caregiver responsibilities ever affected your job?	Yes • Somewhat • No • NA • Declined

If so, how?

Notes:

Caregiver's Interest

What Caregiver services are you interested in receiving? Respite • Supplemental Services • Referral • Counseling • Education

SERVICES REQUESTED

CHECK ALL THAT APPLY

- ☐ Respite care
- ☐ Respite care for an Alzheimer's or dementia patient
- ☐ Nutritional supplements *(Boost, Ensure, Jevity, etc.)*
- ☐ Incontinence supplies *(Depends, Wipes, etc.)*
- ☐ Assistive technology *(Shower chair, walker, etc.)*
- ☐ School related expenses/Afterschool programs *(For seniors raising children)*

ALZHEIMER'S DISEASE AND RELATED DISORDERS

PHYSICIAN DIAGNOSIS STATEMENT

To be completed and signed by patient's physician

Qualifications for the Respite Assistance Program depends on the patient's diagnosis. This respite program serves patients with Alzheimer's disease and related dementias.

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

CAREGIVER OR RESPONSIBLE FAMILY MEMBER

Name: _____

Telephone: _____

PHYSICIAN INFORMATION

Name: _____

Signature: _____

Telephone: _____

Date: _____

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ Alzheimer's Disease
- ☐ Creutzfeldt-Jakob Disease
- ☐ Vascular Dementia
- ☐ Lewy-Body Dementia
- ☐ Huntington's Disease
- ☐ Pick's Disease
- ☐ Parkinson's Disease
- ☐ Mixed Dementia

Caregiver's Well-Being Module

SE1

During an average week, how many days are you in touch by phone, Internet (email), or in person with a friend, neighbor, or relative who does not live with you?

_____ **None** ____ **1 Day** ____ **2 Days** _____**3 Days** ____ **4 Days** ____**5 Days** ____ **6 Days** ____ **Every Day**

SE2

Thinking about how often you are in touch with friends, neighbors, and relatives is this

_____Not Enough _____ About Enough _____Too Much

SE3

During an average week, how many days do you leave home to go to a movie, sports event, club meeting, class, or place of worship?

_____ **None** ____**1 Day** ____ **2 Days** ____**3 Days** ____ **4 Days** ____**5 Days** ____ **6 Days** ____**Every Day**

SE4

Regarding your present social activities, do you feel that you are doing

_____ Not Enough _____ About Enough _____ Too Much

SE5

In general, how would you describe your emotional well-being?

_____ Excellent _____ Very Good _____Good _____ Fair _____ Poor

SE6

During the past 30 days, how often have you had difficult or painful feelings such as stress, grief, worry, anger or loneliness?

_____ Always _____ Usually _____ Sometimes _____ Rarely _____Never

SE7

During the past 30 days, to what extant have feelings such as stress, grief, worry, anger or loneliness interfered with your normal social activities with family, friends, neighbors, or groups?

_____Always _____ Usually _____ Sometimes _____ Rarely _____Never