

Family Caregiver Support Program: Caregiver Re-Enrollment Interview Questions

Advocate:	Contact Method: <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> E Mail <input type="checkbox"/> In-person	Date:						
Caregiver Information								
First Name:	M:	Last Name:	DOB:					
Caregiver Contact Information Verification: <input type="checkbox"/> No Change <input type="checkbox"/> New Phone Number: <input type="checkbox"/> New Address:								
Services Requested (Check all that apply): <input type="checkbox"/> Respite <input type="checkbox"/> Supplemental <input type="checkbox"/> Seniors Raising Children <input type="checkbox"/> Training <input type="checkbox"/> Education <input type="checkbox"/> Counseling								
Care Receiver Information								
First Name:	Last Name:		DOB:					
Changes in Care Receiver Residence? <input type="checkbox"/> No Change <input type="checkbox"/> New Address:								
Changes in Care Receiver Health? Dx of Dementia? <input type="checkbox"/> Yes <input type="checkbox"/> No Dx on File? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Current Services provided to the Care Receiver: <input type="checkbox"/> None <input type="checkbox"/> Home Health <input type="checkbox"/> Hospice <input type="checkbox"/> CLTC <input type="checkbox"/> VA <input type="checkbox"/> Other								
Caregiving Time and Employment Update								
Are you paid to provide care? <input type="checkbox"/> Yes <input type="checkbox"/> No								
On average how many hours per week do you spend providing care?								
Current Caregiver Employment Status: <input type="checkbox"/> Not employed <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time								
Caregiver Health and Wellness Update								
How do you rate your health?	Excellent <input type="checkbox"/>	Above Average <input type="checkbox"/>	Average <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>			
CG Health Notes:								
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	Everyday <input type="checkbox"/>
Thinking about how often you are in touch with friends neighbors and relatives this is:	Not Enough <input type="checkbox"/>		About Enough <input type="checkbox"/>			Too Much <input type="checkbox"/>		
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	Everyday <input type="checkbox"/>
Regarding your present social activities do you feel that you are doing:	Not Enough <input type="checkbox"/>		About Enough <input type="checkbox"/>			Too Much <input type="checkbox"/>		
In general how would you describe your emotional well- being?	Excellent <input type="checkbox"/>	Very Good <input type="checkbox"/>		Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>		
During the past 30 days how often have you had difficult or painful feelings such as stress grief worry anger or loneliness?	Always <input type="checkbox"/>	Usually <input type="checkbox"/>	Sometimes <input type="checkbox"/>			Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	
During the past 30 days to what extent have feelings such as stress grief worry anger or loneliness interfered with your normal social activities with family friends neighbors or groups?	Always <input type="checkbox"/>	Usually <input type="checkbox"/>	Sometimes <input type="checkbox"/>			Rarely <input type="checkbox"/>	Never <input type="checkbox"/>	