LHSA
A Community Action Agency

GRANDPARENTS RAISING GRANDCHILDREN INTAKE FORM

Name: _____ Phone_____
(Last) (First) (MI) (cell or house)

Address: _____
(Street) (City, state, zip code)

Date of Birth _____ Email Address _____

Please mark all that apply:

___ Past-due notice on utility
___ No dental insurance
___ No health insurance
___ No vision insurance
___ Dementia
___ Raising grandchildren
___ Utility shut-off notice
___ Food Stamps $ _____
(Amount received monthly)
___ On Dialysis

Please answer the following:

Disabling Condition: __ Yes __ No
U.S. Military Status: __ None __ Active Duty __ Veteran
Health Insurance: __ None __ Direct Purchase __ Employment Based __ Medicaid __ Medicare
Poverty Level: __ Below 100% __ Over 100% __ I don't know
Housing: __ Own __ Rent __ Affordable __ Safe
Energy Bills: __ Pay easily __ Struggle to pay
Transportation: __ Own, reliable vehicle __ No or unsafe vehicle
Food: __ Have enough food for the month __ Do NOT have enough food for the month
Clothing: __ Can afford clothes __ Cannot afford clothes __ Use clothing banks
Medicine: __ Can afford __ Cannot afford
Child Care: __ I take care of my grandchildren __ Others take care of my grandchildren

Emergency Contact: _____ Relationship to Client: _____

Phone (Home): _____ Phone (Mobile): _____

Hospital of Choice: _____ Hospital City: _____

I understand that the confidential information I am providing on this form will be used for state and federal reporting requirements, program management, quality assurance, public safety, and research. No other use of personal identifying information on this form is intended unless I authorize it or a court orders it.

Printed Name: _____

Signature: _____ Date: _____

CAREGIVING HISTORY

Please circle all the answers that apply to you and fill in the blanks. (Care Recipients are the children in your care, usually your grandchildren.)

How did you hear about this program?
1. Newspaper 2. Television 3. Brochure 4. Friend 5. Agency 6. Website
7. Physician 8. Health Care Provider 9. Other

What is your relationship to Care Recipients?
1. Grandparent Other _____

How long have you been taking care of Care Recipients?
1. 0-6 months 2. 7-12 months 3. 13-36 months 4. 37+ months

How long does it take Care Recipient to get to your home?
1. Live together 2. Less than 1 hour 3. 1-3 hours 4. More than 3 hours

How often do you care for Care Recipients?
1. Daily 2. Less than 1 hour a day 3. Several times per day 4. Weekly 5. Monthly
6. Occasionally

Do you provide Hand On Care? (toileting, grooming, bathing, diapering) Yes No
If yes, Hand On Care Frequency (time): 1. Less Than 1 Hour 2. 1-3 Hours 3. More Than 3 Hours
If yes, Hand On Care Frequency (per): 1. Per Day 2. Per Week 3. Per Month

Are you employed?
1. Full Time 2. Part Time 3. Not Employed

How is your health?
1. Excellent 2. Good 3. Fair 4. Poor

Are friends or other family members willing to help? Yes No

Your total number of Care Recipients _____
Your number of Primary Care Recipients _____

Your total number of dependents:
Under Age 19 _____ Age 19-59 _____ Over Age 59 _____

What is the status of the Care Recipients? (circle all that apply)
Informal Guardianship Foster Care Legal Custody Adoption Other

What are the reasons for this Care Relationship? (circle all that apply)
Abandonment Pregnancy Substance Abuse Mental/Emotional Illness
Incarceration Unemployment Divorce Illness Death Other

Do any of the Care Recipients' parents live with you? Yes No

Do Care Recipients have any of the following Special Needs? (circle all that apply)
Learning Disability Emotional Impairment Physical Disability Developmental Disability

Client Name: _____ Primary Language Spoken in Household: _____ Date:_____

Please use the abbreviations/terms at the bottom of this page to fill in the chart below. All members listed here must live in your household.

HOUSEHOLD DEMOGRAPHICS

FIRST NAME AND MI	LAST NAME	RELATION TO HEAD OF HOUSEHOLD	DATE OF BIRTH Month/day/year	SEX (M or F)	RACE	HISPANIC (YES OR NO)	EDUCATION LEVEL	MARITAL STATUS	PREGNANT (YES or NO)	MONTHLY INCOME	INCOME SOURCES
		HEAD									

RELATION TO HEAD OF HOUSEHOLD

I = Individual
C = Child
G = Grandchild
P = Parent
NR = Non-relative
S = Spouse
SC = Stepchild
FC = Foster Child
P = Partner

RACE

A = Asian
BR = Bi-racial or multiracial
B = Black or African American
W = Caucasian or White
NA = Native American
PI = Pacific Islander
AI = Asian Indian

EDUCATION LEVEL

College = adult who attended college
Grade 10, 11, 12 = adult who finished this grade
HS/ GED = adult who finished High School or obtained GED
Grade 9 or less = adult who finished grade 9 or lower
Preschool = child attending now
Head Start = child attending now
Youth grade 7-8 = youth attending now
Youth grade 9-12 = youth attending now
Child grade 1-6 = child attending now

MARITAL STATUS

D = Divorced
LS = Legally separated
M = Married
P = Partner
S = Single/ Never married
W = Widowed

GRG PRE-SELF ASSESSMENT

For each of the following questions, there are four possible responses. Please choose the answer that mostly describes your response.

I am worried:	**(4) Strongly Agree**	**(3) Agree**	**(2) Disagree**	**(1) Strongly Disagree**
Raising grandchildren today is more challenging than raising my own children				
I don't have all the information about the young generation to help me better understand my grandchildren				
I don't have all the resource to make sure my grandchildren and I stay healthy				
I don't know where to get the help I need for my grandchildren and myself				
I feel isolated raising my grandchildren alone and have no time for myself				
I'm in need of the following help:				
Finding Household items				
Financial Resources				
Transportation				
Food				
Clothing				
Emotional support				
Stress relieve				
Parenting Skill				
Handling grandchildren's challenging behavior				
Supporting my special needs grandchildren				

I'm also in need of help with the following daily living activities:

Activities of Daily Living (□None □All)		**Instrumental Activities of Daily Living (□None □All)**	
□ Eating / Feeding	□ Toileting	□ Shopping	□ Cooking Meals
□Dressing	□Bladder Function	□ Handling Finances	□ Reheating Meals
□ Bathing	□ Bowel Function	□ Heavy Cleaning	□ Taking medication
□ Walking	□ Wheeling	□ Light Cleaning	□ Using Phone
□ Stair Climbing	□ Transferring	□ Using Public Transportation	□ Doing Laundry
□ Bed Mobility	□ Mobility level	□ Using Private Transportation	□ Heating home
		□ Keeping Appointments	

Name:	**Date:**

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