LHSA
A Community Action Agency

GRANDPARENTS RAISING GRANDCHILDREN INTAKE FORM

Name: _____ _____ _____ Phone _____
(Last) (First) (MI) ☐ mobile ☐ landline

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
☐ Kinship care
☐ Utility shut-off notice
☐ . NAŘƎŜ / I·NŘ $ _____
(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 Caregiver:** _____

Emergency Contact Phone: _____ ☐ **Landline** ☐ **Mobile**

Caregiver Hospital of Choice: _____ **Hospital City:** _____

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	

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.

CAREGIVING HISTORY

Please answer the following questions about your relationship with the Care Recipients. (Care Recipients are the children in your care, usually your grandchildren.)

How did you hear about this program? If Other, please write in box. Choose one

What is your relationship to Care Recipients? Choose one

How long have you been taking care of Care Recipients? Choose one

How long does it take Care Recipient to get to your home? Choose one

How often do you care for Care Recipients? Choose one

Do you provide Hands-On Care? (toileting, grooming, bathing, diapering) Choose one

How much time do you provide Hands-On Care? Choose one

How frequently do you provide Hands-On Care? Choose one

Are you employed? Choose one

How is your health? Choose one

Are friends or other family members willing to help? Choose one

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? (check all that apply)

☐ Informal ☐ Guardianship ☐ Foster Care ☐ Legal Custody ☐ Adoption ☐ Other

What are the reasons for this Care Relationship? (check all that apply)

☐ Abandonment ☐ Teen 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? (check all that apply)

☐ Learning Disability ☐ Emotional Impairment ☐ Physical Disability ☐ Developmental Disability

HOUSEHOLD DEMOGRAPHICS

FAMILY NAME _____ PRIMARY LANGUAGE SPOKEN IN HOUSEHOLD _____ DATE _____

Please complete all the information requested for each person living in your household.

1) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

2) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

3) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

4) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

5) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

6) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

7) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: _____ INCOME SOURCES: _____

8) FIRST AND LAST NAME: _____ RELATIONSHIP TO HEAD Of HOUSEHOLD: _____

DATE OF BIRTH: _____ SEX: male ☐ female ☐ MARITAL STATUS: _____

DISABLED: yes ☐ no ☐

PREGNANT: yes ☐ no ☐

RACE: _____ HISPANIC: yes ☐ no ☐ EDUCATION LEVEL: _____

MONTHLY INCOME: ___________________________ INCOME SOURCES: ___________________________

OLHSA

A Community Action Agency

Release of Information for OLHSA's Grandparents Raising Grandchildren Program

I _____ understand that the confidential information I am providing on my Grandparents Raising Grandchildren Intake and my Household Demographics forms 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.

I declare to the best of my knowledge, I am the only member of my household designated above who has applied for assistance in this program. Further, I certify that all information on the Intake and Household Demographics forms is true and correct realizing misrepresentation is illegal and violations will be pursued. I hereby release any information on these documents to agencies to which I may be referred.

I also declare that I am a person 55 years or older. As a recipient of an OLHSA Older Adult Services program funded by the Area Agency on Aging 1-B (AAA1-B) funds, I give my consent to release information about myself, which may be necessary to secure services, follow-up assistance, and that emergency information can be shared and/or emergency contacts notified in the event of an emergency. I give my consent to have my demographic data reported to the National Aging Program Information System (NAPIS) if applicable. I understand that this information will only be released to an appropriate management person, applicable funding source representative, or emergency contact while I am a client of an OLHSA program. I understand that my name, address, and phone number will be supplied to the staff or volunteers by email in order for them to provide services to me. I hereby fully indemnify and hold harmless the OLHSA Board, Staff, Administration, AAA1-B, and assigns from any and all expenses and liability of any kind which may arise out of or in connection with the performance of OLHSA'S Older Adult Services Program.

_____

Participant's Printed Name

_____

Participant/Proxy Signature Date

Aaa2017\grg release of information