

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:

<input type="checkbox"/> Past-due notice on utility	<input type="checkbox"/> Dementia	<input type="checkbox"/> Food Stamps \$ <input type="text"/>
<input type="checkbox"/> No dental insurance	<input type="checkbox"/> Raising grandchildren	(Amount received monthly)
<input type="checkbox"/> No health insurance	<input type="checkbox"/> Kinship care	<input type="checkbox"/> On Dialysis
<input type="checkbox"/> No vision insurance	<input type="checkbox"/> Utility shut-off notice	

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 (<input type="checkbox"/> None <input type="checkbox"/> All)	Instrumental Activities of Daily Living (<input type="checkbox"/> None <input type="checkbox"/> All)		
<input type="checkbox"/> Eating / Feeding	<input type="checkbox"/> Toileting	<input type="checkbox"/> Shopping	<input type="checkbox"/> Cooking Meals
<input type="checkbox"/> Dressing	<input type="checkbox"/> Bladder Function	<input type="checkbox"/> Handling Finances	<input type="checkbox"/> Reheating Meals
<input type="checkbox"/> Bathing	<input type="checkbox"/> Bowel Function	<input type="checkbox"/> Heavy Cleaning	<input type="checkbox"/> Taking medication
<input type="checkbox"/> Walking	<input type="checkbox"/> Wheeling	<input type="checkbox"/> Light Cleaning	<input type="checkbox"/> Using Phone
<input type="checkbox"/> Stair Climbing	<input type="checkbox"/> Transferring	<input type="checkbox"/> Using Public Transportation	<input type="checkbox"/> Doing Laundry
<input type="checkbox"/> Bed Mobility	<input type="checkbox"/> Mobility level	<input type="checkbox"/> Using Private Transportation	<input type="checkbox"/> Heating home
		<input type="checkbox"/> 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.

What is your relationship to Care Recipients?

How long have you been taking care of Care Recipients?

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

How often do you care for Care Recipients?

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

How much time do you provide Hands-On Care?

How frequently do you provide Hands-On Care?

Are you employed?

How is your health?

Are friends or other family members willing to help?

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