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Family Caregiver Services Intake Form

Tell us about yourself.

Today's Date: / /	Preferred Phone: ( )	
First Name:	Last Name:	MI:
Date of Birth: / /	Email:	

Address: **City:** **State:** **Zip:**

The following data is asked by our funders and will not be disclosed by name.

Gender: ☐ Female ☐ Male ☐ Other | **Primary Language:** ☐ English ☐ Other:

Check the racial categories that apply to you:
☐ White ☐ Asian ☐ African American/Black ☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander ☐ Other:

Are you Hispanic or Latino? ☐ Yes ☐ No | **Are you a veteran?** ☐ Yes ☐ No

Do you live alone? Yes No

If Yes, is your annual household income more than $13,590? Yes No

If No, is your annual household income more than:

If 2 people, is your annual household income more than $18,310?	Yes	No
If 3 people, is your annual household income more than $23,030?	Yes	No
If 4 people, is your annual household income more than $27,750?	Yes	No
If 5 people, is your annual household income more than $32,470?	Yes	No
If 6 or more people, is your annual household income more than $37,190?	Yes	No

My relationship to the person to whom I provide informal care:

☐ Wife ☐ Daughter/Daughter-in-law ☐ Brother ☐ Other Relative

☐ Husband ☐ Son/Son-in-law ☐ Sister ☐ Non-Relative ☐ Domestic Partner/Civil Union

Information about the person being cared for:

Address:	City	State:	Zip:

Date of Birth: / /

Or Age:

Gender: ☐ Female ☐ Male ☐Other

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Are you interested in learning about any other services?

☐ Meals ☐ Transportation ☐ Nutrition Counseling ☐ Legal Assistance ☐ Caregiver Support

☐ Options to stay at home ☐ Options to return to home ☐ Health and Wellness Classes

This section to be completed by the provider.

Consumer:

Provider:

☐ New Intake Form ☐ Updated Intake Form

Check the box next to the service provided:

☐ FC Information & Assistance

☐ FC Case Management

☐ FC Counseling

☐ FC Congregate Nutrition

☐ FC Emergency Response System on

☐ FC Home Delivered Nutrition

☐ FC Support Groups

☐ FC Options Counseling

☐ Respite *(indicate type below):*

- ☐ In-home
- ☐ Out-of-home (day)
- ☐ Out-of-home (night)
- ☐ Other

☐ FC Supplemental Services

- ☐ Assistive Technology/Durable Equipment
- ☐ Consumable Supplies
- ☐ Home Modification/Repair
- ☐ Other