LHSA
A Community Action Agency

GRANDPARENTS RAISING GRANDCHILDREN INTAKE FORM

PARTICIPANT INFORMATION

Name: _____ Phone_____
(Last) (First) (MI) (cell, house, text)
Address: _____
(Street) (City, state, zip code)

Email Address _____

Please mark if the following applies:

__ Disabled
__ Medicaid/Medicare
__ No dental insurance
__ No health insurance
__ No vision insurance
__ Dementia
__ Veteran
__ Past-due notice on utility
__ Raising grandchildren
__ Utility shut-off notice
__ Food Stamps $ _____ Amount received monthly
__ On Dialysis

ASSESSMENT/BASELINE DATA

Housing: Do you own your own home or rent?_____
Housing: Is your home affordable and safe? _____
Energy: Can you pay your utility bills without struggling? _____
Transportation: Do you have a vehicle? Is it reliable? _____
Food: Does your household have enough food for the month? _____
Clothing: Can you afford clothing? Do you use clothing banks? _____
Medicine: Are your medications affordable? _____
Child Care: Who provides child care for your grandchildren? _____

CAREGIVER HISTORY

1. How did caregiver hear about this program? (circle answer)
Newspaper Television Brochure/Flyer Friend Agency Website Physician Health Care Provider Other

2. Caregiver relationship to Care Recipient (circle all that apply):
Spouse Daughter Son Daughter-In-Law Son-In-Law Parent Grandparent Other Relative Non-Relative

3. How long has the Caregiver provided care to the Care Recipient?
0-6 months 7-12 months 13-36 months 37+ months

4. How long does it take to get to the Care Recipient's home?
Less than 1 hour 1-3 hours more than 3 hours Caregiver lives w/ Care Recipient

5. Caregiver provides care to Care Recipient:
Daily Several times a week Weekly Less than 1 day/week Monthly Occasionally

6. Does the Caregiver provide hands-on care to Care Recipient? Yes No

If yes, hands-on care is provided: Less Than 1 Hour 1-3 Hours More Than 3 Hours
Per Day Per Week Per Month

7. Caregiver is employed: Full Time Part Time Not Employed

8. Caregiver's health is: Excellent Good Fair Poor

9. Are other friends or family members willing and capable to help care for the Care Recipient?
Yes No

10. How many Care Recipients does Caregiver care for? _____
10a. How many is the Caregiver the primary caregiver for? _____

11. How many dependents does the Caregiver have?
Under Age 19 _____ Age 19-59 _____ Over Age 59 _____

12. Is this a Kinship Care family/situation? Yes No

13. Status of children in care (circle all that apply):
Informal Arrangement Guardianship Foster Care Legal Custody Adoption Other

14. Reasons for Kinship Care (circle all that apply):
Abandonment Teen Pregnancy Substance Abuse Mental/Emotional Illness
Incarceration Unemployment Divorce Illness Death Other

15. Are any of the children's parents also living with Caregiver? Yes No

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship to Client: _____

Address _____

Phone (Home): _____ Phone (Work) _____

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: _____