OLHSA
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
☐ 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 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.

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