

CONFIDENTIAL

SENIOR ASSESSMENT

DATE: _____

STAFF: _____

- See Dementia Assessment
- See H2H Assessment



ENROLLMENT: New Update Temporary NFCSP/Statewide Respite

PERSONAL

Client 1:

Salutation: _____ First: _____ MI: _____ Last: _____ Nickname: _____

Birth Date: _____ SSN (Social Security): 000 - 00 - _____

Gender: Female Male Transgender Decline to State Other _____

Veteran: Yes No Military Branch: _____

Client 2: *(Use a separate intake form for each senior client; Cross reference clients in files)*

First: _____ MI: _____ Last: _____

Birth Date: _____ SSN (Social Security): 000 - 00 - _____

Gender: Female Male Transgender Decline to State Other _____

Veteran: Yes No Military Branch: _____

Marital Status

Divorced Legally Separated Married Single Widowed Civil Union Unknown

RESIDENTIAL ADDRESS

Best Phone Number: (____) _____ - _____ Second Best Phone Number: (____) _____ - _____

Street 1: _____

Street 2: _____

City: _____ State: CA Zip Code: _____ - _____

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SENIOR CLIENT NAME: _____ **DATE:** _____ **STAFF:** _____

EMERGENCY CONTACT #1

Relationship: _____

First: _____ MI: _____ Last: _____

Best Phone Number: (____) ____-____ Second Best Phone Number: (____) ____-____

Street 1: _____

Street 2: _____

City: _____ State: CA Zip Code: _____ - _____

EMERGENCY CONTACT #2

Relationship: _____

First: _____ MI: _____ Last: _____

Best Phone Number: (____) ____-____ Second Best Phone Number: (____) ____-____

Street 1: _____

Street 2: _____

City: _____ State: CA Zip Code: _____ - _____

SITUATION

Supplemental Caregiving Services/Professional or Informal

Level of Care: _____ Service/Care Program: _____

Provider Name: _____

Caregiver/Care Recipient (Respite Care)

Primary Caregiver (name): _____

Relationship

Adult Child (Daughter/Son/Daughter-in-Law/Son-in-Law)

Family Member (Wife/Husband/Other Elderly Relative/Other _____)

Friend (Non-Relative/Other Elderly Non-Relative)

Default Agency Contact: _____

Notes:

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SENIOR CLIENT NAME: _____ **DATE:** _____ **STAFF:** _____

CHARACTERISTICS

Meal Eligibility

- Age 60 and Older Disabled in Elderly Housing Helper/Spouse Shop&Drop
- Not Indicated Type Other Tribal Specification Volunteer

Mobility

- Wheelchair Walker Cane Other: _____

Mood

Today _____ In general _____

Demographics

Race

- Asian Black or African American Hispanic/Latino White
- Native American/Alaskan Native Native Hawaiian/Pacific Islander
- Other _____

Ethnicity

- Hispanic/Latino Not Hispanic/Latino Unknown

Housing

- Private Home Private Apartment Senior Housing
- Congregate Housing Public Housing

Volunteer Caregiving occasionally makes exceptions made for:

- Residential Care Home Nursing Home Assisted Living Other Unknown

Living Arrangements

- Alone With Spouse/Partner With Spouse and Child/Children
- With Child, No Spouse With Other Relatives With Others Unknown

Income (alone: _____/month; with spouse: _____/per month) FMP/HUD

Extremely Low/Very Low: \$23,600 / \$26,950

Very Low/Low: \$39,250 / \$44,850

Low/Moderate: \$62,800 / \$71,800

Non-Low: > \$62,800 / > \$71,800

Pets: Yes No What kind/How Many? _____

Notes:

HEALTH NOTES

MediCAL Yes No

Insurance: _____

Cal Fresh Yes No

Nutrition/Groceries

Delivered Self Service/Family/Friend: _____

Needs Meal Prep Shop & Drop

Functional Status:

Functionally Impaired (Needs assistance with 1+ ADLs)

DISABLED (Needs assistance with 3+ ADLs)

___ Feeding ___ Dressing ___ Hygiene: Bathing/Washing ___ Toileting

___ Ambulating: Walking independently, Transferring ___ Continence ___ Cognitive

Instrumental Activities of Daily Living (Volunteer Caregiving services needed)

___ Visiting/Walking ___ Meal Prep ___ Shopping ___ Economic Solutions

___ Phone ___ Repairs/Honey Do Crew ___ Yardwork/Building Bridges

___ Housekeeping/Building Bridges ___ Pet Support ___ Dementia Friendly Relief

___ Transportation ___ Medication Management ___ Mail/Paperwork ___ Respite

Concerns:

___ Incontinence ___ Signs of aggravation ___ Home Environment

___ Pets ___ Family Dynamics ___ Other: _____

SOCIAL NOTES

Referred by: _____

Religion: _____ Congregation: _____

Interests:

SENIOR CLIENT NAME: _____ DATE: _____ STAFF: _____

VOLUNTEER CAREGIVING ACTION PLAN

- One-on-One Match Desired *(please advise Matches can takes weeks or months)*
 - Meal Prep Shopping Pet Support Phone
 - Economic Solutions Mail/Paperwork Yardwork Visiting/Walking
 - Housekeeping Transportation
- Transportation
 - No longer driving
 - Public Paratransit is an option
 - Volunteer Driver Recommended *(please advise two weeks notice recommended)*
- Phone Friend Assigned _____ *(please advise that this is mandatory)*
- Building Bridges/Housekeeping
 - Eligible for Building Bridges when available; Call to request
 - Welcome Call scheduled with Youth Coordinator
- Honey Do Crew project: _____
- Hospital to Home *(Use H2H Form for tracking)*
 - Transportation Building Bridges Meal Prep Pet Care _____
- Economic Solutions
- Respite
 - Dementia Friendly Relief Volunteer
 - Dementia Stage _____ as stated by _____
- Shop & Drop

NOTES/OUTSIDE REFERRALS

For Office Use:

- Update Call Log Disposition Create Hard File Case Management Form
- Temporary Enrollment Add to 1:1 Waiting List Add to Phone Friends List
- Assign to Volunteer (H2H/Economic Solutions): _____
- Create FMP Record One Unit/Case Management Additional Units: _____
- __Building Bridges __Dementia Friendly __ Economic Solutions __ Honey Do Crew __ H2H __Mail/Paperwork
- __Housekeeping __Meal Prep __Pet Support __Phone __Respite __Shopping __Transportation __Visiting
- __Yardwork



I, _____, give permission to release information pertinent to coordinating care to the Executive Director and/or Senior Engagement Coordinator at CAREGIVERS: *Volunteers Assisting the Elderly*, 1765 Goodyear Avenue, Suite 205, Ventura, California 93003. Telephone: (805) 658-8530.

Full Name:

Address:

City:

Phone:

Date of Birth:

Information may be released to:

- CAREGIVERS Executive Director
- CAREGIVERS Senior Engagement Coordinator

This release is designed to help coordinate care between CAREGIVERS and the organizations and agencies who are offering support, such as but not limited to:

- Ventura County Behavioral Health
- Adult Protective Services
- Area Agency on Aging
- An individual's health insurance or medical case worker
- Other:

Since CAREGIVERS does not store social security numbers, please contact me directly for this information if it's required.

Signature:

Date:



PERMISSION TO USE PHOTOS AND VOICE

I hereby give the agent from CAREGIVERS: *Volunteers Assisting the Elderly*, the absolute right and permission to publish, copyright and use my picture and/or my voice in which I may be included in whole or in part, composite or retouched in character or form. These photographs and/or my recorded voice will be used for promotional purposes for CAREGIVERS: *Volunteers Assisting the Elderly*.

If the persons being photographed or recorded are under 18 years of age, I certify that I am his or her parent or legal guardian and I give my consent without reservation to the foregoing on his or her behalf.

Name: _____

Address: _____

Phone: _____

Name of Parent/Legal Guardian/Volunteer (over the age of 18)

Date

Signature of Parent/Legal Guardian/Volunteer (over the age of 18)

Date

Name of Adult Volunteer

Date