National Family Caregiver Support Program

Administered in Dorchester County by
Delmarva Community Services, Inc.
2450 Cambridge Beltway, P.O. Box 592, Cambridge, MD 21613
410-221-1940

Family Caregiver: _____

Relationship to Care Recipient _____ DOB _____

Address _____

City _____ State _____ Zip _____

County _____Phone _____ Sex ___M___F

Race: ___Asian ___Black ___Caucasian ___Native Amer.
___ Hawaiian/Pacific Isl. Native ___ Unknown Other _____

Live alone? __Y __ N Hispanic? __Y __N

Care Recipient: _____DOB_____

SS #_____

Address _____

City _____ State _____ Zip _____

County _____Phone _____ Sex ___M___F

Race: ___Asian ___Black ___Caucasian ___Native Amer.
___ Hawaiian/Pacific Isl. Native ___ Unknown Other _____

Live Alone? __Y __N Hispanic __Y __N Annual Income _____

Describe recipient's condition _____

_____

Are you the primary caregiver? _____

Who can help if you are not available? _____

Are they available on short notice? ___ Yes ___ No

What do you feel are your caregiving limitations or constraints?

___ No particular constraint
___ Poor health, disabled, frail
___ Employed
___ Lack knowledge, skill
__ Financial strain
___ Poor relationship with care recipient
___ lives at a distance
___ Substance abuse – care recipient
___ Providing care to others
___ Other, Explain:

Current employment status? (Full/part time) _____

Have your caregiving and social life and/or employment conflicted? How?

_____

_____

Do you have any other caregiving responsibilities? (children, other adults, etc.)

_____

How many hours a day do you have available to provide care to this recipient?

_____

How many hours a day do you usually spend providing care to this recipient?

_____

How many hours a day does this recipient need?

_____

Describe problems with continued caregiving (if any)

_____

Overall, how stressed do you feel in caring for the recipient?
___ Very stressed ___ Not stressed ___ Somewhat stressed

Do you desire service or support?
___ No ___ Yes, describe need

_____

_____

In the past six months, have there been any significant changes or events in your life? ___ No ___ Yes, explain _____

_____

Are you currently experiencing any emotional concerns or difficulties? ___ No
__ Yes, explain

_____

What is the average monthly cost to the family or consumer for consumable?
supplies? $_____. Description: _____

_____

How did you hear about the program? _____
Signature: _____ Date: _____

CLIENT _____

FUNCTIONAL ASSESSMENT:

Please mark for each statement the description which best describes the amount of help the person you care for needs on a typical day:

Question	Does by self	Needs some assistance	Cannot perform by self
1. Does client need help with light chores around the house?			
2. Does client need help with grocery shopping?			
3. Does client need help preparing a light meal, i.e. sandwich?			
4. Does client need help in getting to places outside of walking distance?			
5. Does client need help eating?			
6. Does client need help getting dressed or changing nightclothes?			
7. Does client need help bathing?			
8. Does client need help with maintaining appearance? (combing hair, shaving, etc.)			
9. Does client need help getting to and from toilet?			
10. Does client need help taking own medication?			
11. Does client need help getting into or out of bed or chair?			
12. Does client need help walking?			
13. Does client need help using the telephone?			
14. Does client need help with handling own money?			
15. Does client need help with planning and decision making?			

Agency Family Agreement

The Delmarva Community Services, Inc. (DCS, Inc.) is the administrating agency for the Eastern Shore Respite Care Program, which offers financial reimbursement for respite care services to an applicant, the applicant's family, or an appropriate representative. Your initials in the blanks in front of the numbers signify you understand and agree with the content of each paragraph. This agreement must be signed, dated and each paragraph initialed in order to receive reimbursement for respite care services.

_____1. As the acting representative for _____, I understand that I have the option to recruit my own care worker. If I do not have my own care worker(s) I may voluntarily interview, recruit, and choose a care worker from names I have requested from The Functionally Disabled Respite Care Program or another health or social agency. This care worker is not an employee or agent of Delmarva Community Services, Inc./Functionally Disabled Respite Care Program and has not had a criminal background check. I agree that I will not hold Delmarva Community Services, Inc./Functionally Disabled Respite Care Program liable for anything, which affects the health, safety or welfare of the individual receiving services. I as acting representative take full responsibility for monitoring and supervising the care worker(s) I select.

_____2. I understand that _____ will or I will be reimbursed for these services and we are responsible for paying the care worker. I further understand that the Eastern Shore Respite Care Program will be responsible for payment only if the Respite Care office has given prior approval. Approval of respite care services will be based on the amount of time allotted per individual and availability of funds.

_____3. Delmarva Community Services' staff has explained that I need to consult a tax advisor to receive advice concerning my tax responsibilities.

_____4. The Respite Care staff has explained one of the options for income tax reporting; the Household Employee's Tax Form, and I will discuss this and any other options with a tax advisor.

_____5. I understand that I take full responsibility for monitoring, hiring, firing, training and tax reporting of the care workers.

_____6. The services requested will be specifically provided to _____. This agreement is valid for respite care services that occur within a one-year period beginning _____ and ending _____.

Signature _____Date _____

Relationship to client _____