|  |  |
| --- | --- |
| **dhsslogo** | **Care Recipient Assessment**  **Form CF-044** |

|  |  |
| --- | --- |
| Date of Assessment: | Agency Name: |
| Caregiver Name: | Person Reporting: |

|  |
| --- |
| Program:  Case Management  Respite  CRC  Other |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last Name: | First Name: | | | | | Male | Female |
| Address: | | | Apt #: | County:  NCC  Kent  Sussex | | | |
| Address 2 (Apt. Complex Name or Development Name): | | | | | | | |
| City: | State: | Zip: | | | | Rural:  Yes  No | |
| Telephone 1: | Telephone 2: | | | |  | | |

|  |  |
| --- | --- |
| Care Recipient’s Ethnicity:  Hispanic or Latino  NOT Hispanic or Latino | |
| Race: | White – Non Hispanic |
| White – Hispanic |
| American Indian/Alaska Native |
| Asian |
| Black or African American |
| Native Hawaiian or Other Pacific Islander |
| Other Race |
| Reporting 2 or More Races:  YES | |
| Race Data Missing:  YES | |

|  |
| --- |
| Care Recipient’s Date of Birth (DOB) |
| If DOB is unable to be collected, please check appropriate date range:  <50  55-59  75-84  50-54  60-74  85+ |
| If the care recipient is under age 60, is he/she diagnosed with early-onset dementia?  Yes  No |

|  |  |  |
| --- | --- | --- |
| Does the care recipient live alone? | Yes | No |
| If you answered “no” how many in the household? |  | |
| Is the care recipient’s income level below Federal Poverty? | Yes | No |
| Income Level – NOT Reported | | |

|  |  |
| --- | --- |
| *Federal Poverty Income Levels:* | |
| 1 Person Household | < $12,060 |
| 2 Person Household | < $16,240 |
| 3 Person Household | < $20,420 |
| 4 person Household | < $24,600 |

*Updated 10/11/2017*

|  |  |  |
| --- | --- | --- |
| How many of the following six ADL’s is the care recipient **UNABLE** to perform without personal assistance, stand-by assistance, supervision or cues: | Dressing  Bathing  Toileting  Transferring in/out of bed/chair  Eating  Walking | Total Care Recipient ADL’s:  0  1  2  3 + |

|  |  |  |  |
| --- | --- | --- | --- |
| How many of the following eight IADL’s is the care recipient **UNABLE** to perform without personal assistance, stand-by assistance, supervision or cues: | Preparing Meals  Medication Management  Money Management  Using the Telephone  Doing Heaving Housework | Doing Light Housework  Access Transportation with Assistance  Shopping for Personal Items | Total Care Recipient IADL’s:  0  1  2  3 + |

|  |  |  |
| --- | --- | --- |
| Services Recommended to the Care Recipient Include: | Personal Care  Adult Day Care  Meals  ERS Services  Financial Assistance  Legal Assistance | Home Modification  Assistive Technology  Support Group  Caregiver Resource Center  Transportation  Other: |

|  |
| --- |
| Notes: Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| Care Recipient’s Suggested Donation Amount: | $ | Per:  Week  Month |