MBA Title III-E Caregiver Questionnaire

Contents **Initials/Date**

Part I. Caregiver Program Registration

Please complete this form to the best of your ability. Shaded areas are for office use only.

Contact Date / /	**Status**	**AAA Region**	**NAPIS ID Number** - -

Section A. Basic Demographics

Last Name:	First Name:	Middle Initial:
Lives in Rural Area (Circle One): Yes □ No	Gender: □ Female □ Male □Unspecified	Date of Birth: / /

Address:	Address #2:

City:	State:	Zip Code:	County:

Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )

Section B. Social History

Race (Circle one): □ American Indian/Alaskan □ Asian White Hispanic White not Hispanic 2 or More Races □ Black/African American □ Native Hawaiian/Pacific Islander □ Other

Ethnicity (Circle one)
□ Hispanic or Latino
□ Non-Hispanic

Section C. Care Receiver

What is the care receiver's name?

(Last)_____ (First)_____ (Middle Initial)_____

What is the care receiver's date of birth? _____/_____/_____

What is your relationship to the care receiver? (Circle one)

□ Husband □ Wife □ Son/Son-in-law □ Daughter/Daughter-in-law □ Other Relative

□ Non-Relative □ Unknown

What is the approximate household income of the care receiver? (Circle one)

1 person in a single or multiple, ***non-spousal*** household

Under $973/month $973 to $1,459/month $1,460 to $1,945/month More than $1,945/month Unknown

2 person ***spousal*** household

Under $1,311/month $1,311 to $1,966/month $1,967 to $2,622/month More than $2,622/month Unknown

Section D. Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the Area Agency on Aging and the Minnesota Board on Aging to create statistical reports and may be used by service providers to help identify other services from which I may benefit. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Signature: _____ Today's Date: _____

Part II. Caregiving Questions

What is your most immediate need or concern?

How did you hear about this agency/organization?

☐ **Brochure** ☐ **Newspaper** ☐ **Friend or acquaintance** ☐ **Internet** ☐ **Website**

☐ **Doctor/health clinic** ☐ **Community service/program** ☐ **Other**

Are you currently employed? (Please describe)

☐ **Working full-time** ☐ **Working part-time** ☐ **Not Currently Employed**

Do you live in the same household as the person needing care?

☐ **Yes**
☐ **No If not, what is the distance between households? _____ miles**

Is there anyone else living with you or <NOP> that needs your care or time (e.g., minor children, parent, or other dependent)?

How would you describe your own health?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

What illnesses or medical problems do YOU have that limit your ability to provide care, and do what you need to do? (e.g., chronic pain, diabetes, emphysema, Parkinson's, physical disabilities, mental illness)

Do you have difficulty getting a good night's sleep, 3 or more times per week?

☐ **Yes**
☐ **No**
☐ **Sometimes**

Notes:

Activities of Daily Living

[Note: assistance with two or more ADLs or needs supervision for respite and supp. services]

Can <NOP> walk around inside without any help? ☐ Yes ☐ No	**Can <NOP> bathe or shower without any help? ☐ Yes ☐ No**
Can <NOP> sit up or move around in bed without any help? ☐ Yes ☐ No	**Can <NOP> use the toilet without any help? ☐ Yes ☐ No**
Can <NOP> comb their hair, shave, wash their face, or brush their teeth without any help? ☐ Yes ☐ No	**Can <NOP> dress without any help? ☐ Yes ☐ No**
Can <NOP> get in and out of bed or chair without any help? ☐ Yes ☐ No	**Can <NOP> eat without any help? ☐ Yes ☐ No**

Need for Supervision:

Does <NOP> have issues with memory, thinking, or the ability to make decisions that result in the need for supervision? ☐ Yes ☐ No

Is <NOP> a Veteran? ☐ Yes ☐ No

If Yes, do you or <NOP> receive any Veteran's benefits? Please describe:

Does <NOP> receive assistance from the county or Medical Assistance ☐ Yes ☐ No (ie., does NOP have a county worker?)

What health problems or medical conditions does <NOP> have that need to be managed?

What is your comfort level with <NOP's> medications or treatments?

Are you satisfied with the amount of information you have been given so far about <NOPs> disease or condition (e.g., dementia, stroke, Parkinson's, etc.)? Or, do you have questions that haven't been addressed yet?

☐ Yes ☐ No

Please describe:

What types of UNPAID help or care are you or <NOP> currently receiving from friends, family, neighbors, people from church, or others in the community? (List person, relationship to CG or CR/type of help/how often)

Who would you call in an emergency?

Do you have plans in place for caregiving in the event of an emergency or health care crisis (e.g., who would help/type of help, etc.)?

Do you have concerns about <NOPs> safety? (e.g., falls, driving, cooking, wandering, alcohol or drug use, fire arms, self-harm or harm to you)

☐ **Yes** ☐ **No**

Please describe:

Are there issues that might cause you to consider a higher level of care for <NOP> or a transition into assisted living or a nursing home? (e.g., worsening dementia, falls, incontinence, your physical health, financial or emotional strain, etc.)

Have you and <NOP> done any planning for the future? (Check all that apply)
(CG = caregiver, NOP = older adult)

☐ **Advanced healthcare directive**	☐ **CG**	☐ **NOP**
☐ **Power of attorney**	☐ **CG**	☐ **NOP**
☐ **A will/trust/or estate planning**	☐ **CG**	☐ **NOP**
☐ **Guardianship/Conservatorship**	☐ **CG**	☐ **NOP**

Notes:

Part III: Caregiver Screen*

<Please reflect on your experiences and rate your responses to the statements below. It will help us gain a better understanding of your situation and how to work with you meet your needs>

1. As a result of assisting <NOP>, to what extent have the following aspects of your life changed?					
To what degree have your care responsibilities …	**Not at all**	**A little**	**Moderately**	**A lot**	**A great deal**
(a) Caused conflicts with your relative?	1	2	3	4	5
(b) Decreased time you have to yourself?	1	2	3	4	5
(c) Created a feeling of hopelessness?	1	2	3	4	5
(d) Given your life more meaning?	1	2	3	4	5
(e) Increased the number of unreasonable requests made by your relative?	1	2	3	4	5
(f) Kept you from recreational activities?	1	2	3	4	5
(g) Made you nervous?	1	2	3	4	5
(h) Made you more satisfied with your relationship?	1	2	3	4	5
(i) Caused you to feel that your relative makes demands over and above what he/she needs?	1	2	3	4	5
(j) Caused your social life to suffer?	1	2	3	4	5
(k) Depressed you?	1	2	3	4	5
(l) Given you a sense of fulfillment?	1	2	3	4	5
(m) Made you feel you were being taken advantage of by your relative?	1	2	3	4	5
(n) Changed your routine?	1	2	3	4	5
(o) Made you anxious?	1	2	3	4	5
(p) Left you feeling good?	1	2	3	4	5
(q) Increased attempts by your relative to manipulate you?	1	2	3	4	5
(r) Given you little time for friends and relatives?	1	2	3	4	5

(s) Caused you to worry?	1	2	3	4	5
(t) Made you enjoy being with your relative more?	1	2	3	4	5
(u) Left you with almost no time to relax?	1	2	3	4	5
(v) Made you cherish your time with your relative?	1	2	3	4	5

*Montgomery Burden Scale. Source: Montgomery, R.J.V., E.F. Borgatta & M.L. Borgatta (2000)

Sum Baseline R Score = (a) ___ + (e) ___ + (i) ___ + (m) ___ + (q) ___ = _____
R Score = 13-25 High*; 8-12 Medium*; 5-7 Low

Sum Baseline O Score = (b) ___ + (f) ___ + (j) ___ + (n) ___ + (r) ___ + (u) ___= _____
O Score = 24-30 High*; 18-23 Medium*; 6-17 Low

Sum Baseline S Score = (c) ___ + (g) ___ + (k) ___ + (o) ___ + (s) ___ = _____
S Score = 17-25 High*; 12-16 Medium*; 5-11 Low

**** Note: If scores are in the Medium or High range in ANY one of three burden measures, a referral for a full TCARE® assessment is recommended.***

CES-D Screen

2. The following is a list of the ways you may have felt or behaved recently. For each statement, indicate how many days you have felt this way <u>during the past week</u>.

DURING THE PAST WEEK:	**Rarely or none of the time (less than 1 day)**	**Some or a little of the time (1-2 days)**	**Occasionally or a moderate amt. of time (3-4 days)**	**All of the time (5-7 days)**
a. I was bothered by things that don't usually bother me	1	2	3	4
b. I had trouble keeping my mind on what I was doing	1	2	3	4
c. I felt depressed	1	2	3	4
d. I felt that everything I did was an effort	1	2	3	4
e. I felt hopeful about the future	4	3	2	1
f. I felt fearful	1	2	3	4
g. My sleep was restless	1	2	3	4
h. I was happy	4	3	2	1
i. I felt lonely	1	2	3	4
j. I could not "get going"	1	2	3	4

Source: Center for Epidemiological Studies Depression Scale (CES-D)

Sum **Baseline** *CES-D Score: 26-40 High*; 19-25 Medium*; 10-18 Low*
** If scores medium or high a referral to primary care physician is recommended.*

Part IV. Closing Questions

How much time each week do you have to yourself, to get things done, to socialize with family/friends, relax, or for other purposes?
What would you do more of if you had more time away from caring for <NOP>?
After our conversation today, what do you think are the most immediate issues or concerns that need to be addressed or that you need some assistance with? What things would you like us to address first?
Notes/Additional Questions

Part V. Sample Caregiver Plan

Name **Caregiver ID**

Date of Plan

Initial ☐ **Follow-up** ☐ **3 Month** ☐ **6 Month** ☐ **9 Month** ☐ **12 Month**

Goals: <At least one goal should focus on caregiver's health>

Goal: **Outcome:**		
Goal: **Outcome:**		
Goal: **Outcome:**		
Caregiver Consultant Responsibility		
Caregiver Responsibility		
Caregiver Consultant Name	**Signature**	**Date**
Caregiver Name	**Signature**	**Date**

Live Well at Home

Live Well At Home Rapid Screen© – Family Caregiver

Screen Date: _____

1.	**Does <name of older person (NOP)> need help from someone else to do the following?** a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating **If 2 or more circled → SCORE = 2**	☐
2.	**During the last 6 months, has <NOP> had a fall that caused injuries *or* engaged in behavior problems such as wandering, verbal or physical disruption, or other behaviors that require supervision? Yes No** NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization OR 3 or more of any falls **IF YES circled → SCORE = 2**	☐
3.	**Does <NOP> have a family member/friend give help when she/he needs it? Yes No** **If NO circled → SCORE = 2**	☐
4.	**Do you feel overwhelmed or stressed because of the care you provide for <NOP>? Yes No** **If YES circled → SCORE = 2**	☐
5.	**Have you/<NOP> thought about moving <NOP> to other housing? Yes No** **If YES, where has <NOP> considered moving to?** **If answered NURSING HOME or ASSISTED LIVING (i.e., Housing With Services) → SCORE = 2**	☐
6.	**Does <NOP> live alone? Yes No** **If YES circled → SCORE = 1**	☐
7.	**Do you or your family have concerns about <NOP's> memory, thinking, or ability to make decisions?** **If YES, are you: Very concerned Somewhat concerned** **If VERY CONCERNED circled → SCORE = 2** **If SOMEWHAT CONCERNED circled → SCORE = 1**	☐
	TOTAL SCORE (Sum of Scores For Items 1 Through 7) =	☐
<u>Score and Risk Category</u> **0 = No Risk 1 = Low Risk 2 = Moderate Risk 3 and Higher = High Risk**		