Idaho Caregiver Assessment

Testers: Get Care is the management information system for the Idaho Commission on Aging (ICOA). The Area Agencies on Aging (AAAs) use the system to track clients and report services. If you are not a AAA and are helping ICOA test this assessment and determine if it will be useful to your agency, ignore the Get Care references for now, they are communications to the AAAs.

The information gathered helps the interviewer to understand the caregiver’s circumstances. The assessment is meant as an interview guide. As a result of the assessment process you and the caregiver can personalize suggestions, services, and supports. The assessment process may also help caregivers realize that they need other services, may help them determine how they will spend their respite breaks, and may help them understand they need decision support. Responses are confidential. Let caregivers know that information that is not personal may be gathered and combined with other caregiver responses to help determine if our agencies are reaching priority populations, offering the most needed services, or providing the most helpful referrals. For this assessment, “caregiver” refers to any relationship between a caregiver and a person of any age with special needs. Information about the care-recipient’s needs and desires will be collected in another assessment (Get Care) if needed.

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| **Idaho Caregiver Assessment** |
| 1. Caregiver’s first/last name: Caregiver’s address (this may not be needed after the document is tested and integrated with Get Care): |
| 2. Language preference (may not be needed when in Get Care): |
| 3. Person you care for/care recipient’s first/last name:What is your relationship to the person you care for? (circle response):a. Spouse/partnerb. Parent/Step-Parent/In-lawc. Grandparent/other relative or non-relative of child d. Daughter/Son/In-lawe. Sibling/In-law f. Other Relative g. Non-Relative/friendh. Other (please specify) |
| 4. Emergency contact for caregiver: |
|  5. Were you aware of caregiver support resources prior to making this contact? Y or N If yes, did you make use of caregiver support services in the past? Y or N |
| 6. How did you hear about us (name of your agency)? |
| 7. What prompted you to seek help now? (circle all that apply):a. Care recipient condition changedb. Caregiver health changedc. Family circumstances changedd. Family/friend/acquaintance referrede. Professional/health care provider referred f. Other referral: Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8. How would you describe your social support system? (READ LIST - check ONE that best describes) [ ] excellent, includes willing family members and friends [ ] good, includes family members and friends [ ] fair, minimal support from family or friends [ ] poor, no willing family members or friends |
| 9. Who helps you provide care (may include family and friends at a distance who provide support)?**Name Relationship to Caregiver Assistance Provided** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10. Are there others who could assist you (family, friends, neighbors, club members, volunteers from a religious institution)? Let’s list them:  |
| 11. How long have you been providing care for [care recipient name]? months\_\_\_\_\_\_\_\_\_ years \_\_\_\_\_\_\_\_\_\_  |
| 12. How often do you provide care to [care recipient’s name]?a. Frequently throughout the dayb. Dailyc. Weeklyd. Monthlye. Less than once per month |
| 13. Do you live in the same home as the person for whom you care? Y or N If YES, how well does the environment meet your needs as a caregiver? If NO, how far do you travel to get to the care recipient’s home? |
| 14. Are you also providing care to any other individuals? Y or N If YES, who? (circle all that apply):a. Friend/ neighborb. Spouse/partnerc. Siblingd. Child/childrene. Child/children with a special need or disability under 60 years of agef. Other  |
| 15. Are you, or the person for whom you care, a veteran? Y or N |
| 16. Do you care for someone requiring supervision because of a memory and/or cognitive condition? Y or N |
| 17. What are your strengths as a caregiver? |
| 18. What are the positive aspects of being a caregiver?  |
| 19. Do you have concerns about [the care recipient’s] safety? (e.g., falls, driving, cooking, wandering, alcohol or drug use, firearms, harmful to you or themselves) Y or N If yes, please describe:  |
| 20. Are there issues that might cause you to consider asking someone to relieve you as caregiver, seek more care for [the care recipient], or transition into assisted living or a nursing home? (e.g., worsening dementia, falls, incontinence, your physical health, financial or emotional strain, etc.) Y or N If yes, please describe: |
| 21. Do you think you have a choice about being a caregiver or not? Y or NFollow up discussion might include:Yes (Are you doing alright? Can you continue? Is there anything you need to continue?)No (Is there another family member or person to provide care? Would you consider moving your care receiver into a facility?) |
| 22. How have you coped with challenges or roadblocks in the past? |
| 23. Is there anyone you can call on short notice to fill-in for you as the caregiver? Y or N If YES, does the person in #17 know she/he/they is/are the fill-in contact? Y or N Do you have a plan of care for the fill-in caregiver to follow in your absence? Y or N |
| 24. Do you have an emergency plan for emergency personnel to follow in your absence? Y or N |
| 25. Has your health or/and emotional condition affected your ability to provide care? Y or N |
| 26. During the last 12 months, have you been hospitalized anytime while being a caregiver? Y or N |
| 27. Are you working or going to school/training outside of the home? Y or N If Yes, has working outside the home affected your ability to provide care? Y or NHas providing care impacted your ability to work outside the home or go to school/training? Y or N |
| 28. Do you provide assistance to the care recipient with this activity? Circle all that apply. (If not you then who?):a. Personal care tasks (includes bathing, dressing, transfers to bed/chair/car)b. Homemaker chores (includes meals, laundry, shopping, mowing)c. Transportationd. Managing financese. Financial assistance (POA for finances)f. Health care (includes medication management, wound care, handling equipment, POA for healthcare, understanding health insurance)g. Care management (includes coordinating appointment, advocating for services, monitoring changes made by health care providers, therapists, etc)h. Emotional and/or social supporti. Education or therapeutic plansj. Legal mattersk. Other: Please describe  |

**Modified Caregiver Strain Index**

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| ***Here is a list of things that other caregivers have found to be difficult. Which apply to you? Your situation may be slightly different, but the item could still apply.*** | **Yes, on a regular basis****(2 pts.)** | **Yes, Sometimes****(1 pt.)** | **No****(0 pt.)** |
| **My sleep is disturbed.***For example: person I care for wanders at night; needs**assistance; I can’t sleep* |  |  |  |
| **Caregiving is inconvenient.***For example: helping takes a lot of time; it is a long**drive over to help* |  |  |  |
| **Caregiving is a physical strain.***For example: lifting in or out of a chair/bed/toilet* |  |  |  |
| **Caregiving is confining.***For example: restricts my free time; I cannot go places I**enjoy* |  |  |  |
| **There have been family adjustments.***For example: helping has disrupted my routine; there is**no privacy; family arguments* |  |  |  |
| **There have been changes in personal plans.***For example: I could not go on vacation; I cannot**participate in activities that I enjoy* |  |  |  |
| **There have been other demands on my time.***For example: other family member need me; work* |  |  |  |
| **There have been emotional adjustments.***For example: arguments with family about caregiving;**anger; sadness* |  |  |  |
| **Some behavior is upsetting.***For example: person cared for has memory issues;**outbursts* |  |  |  |
| **It is upsetting to find the person I care for has changed so much from his/her former self.***For example: he/she is a different person than he/she**used to be; unable to do things* |  |  |  |
| **There have been work adjustments.***For example: I have to take time off for caregiving**duties; adjusting schedules; unable to work* |  |  |  |
| **Caregiving is a financial strain.***For example: I use personal finances for caregiving;**unsure about future financial situation* |  |  |  |
| **I feel completely overwhelmed.***For example: I worry about the person I care for; I have**concerns for my future* |  |  |  |
| **Total Score** |  |  |  |

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| 29. 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? |
| 30. If you could eliminate one thing from your daily or weekly routine to make life easier, what would that be? |
| 31. What would you do more of if you had more time away from caring for [your care recipient]? |
| 32. Would you like information, education and/or training about the following?  Check all that apply. (Make sure you have a resource for each through resource database and/or community service contacts). a. How to care for yourself while caring for others (social, physical/health, emotional/mental)b. More information about care recipient’s disease/conditionc. How to engage family members or others to help (difficult conversations, family meetings, mediation)d. Home safety and/or home modifications, assistive devices, or equipmente. Legal and financial issues (Advanced Directive, POAs, living will, estate planning)f. Long-term planning or care options (insurance, public programs, Medicaid, advance care planning, Medicare choices review with SHIBA and/or other benefits)g. In-home support services (homemaker, chore, personal care, meals, shopping)h. Respite care (in-home, out of home)i. Choosing a long-term care facility (level of care needs, costs, research options)j. Support Groups (caregiver, disease specific, on-line)k. Caregiver Training Opportunities (conferences, classes, Powerful Tools for Caregivers)l. Individual counseling optionsm. On-line information and supportsn. Hands-on skills training for personal care tasks (bathing, transferring, toileting)o. Telephone reassurancep. Assistive technology (clock, adapted phone, home monitoring device)q. Other. Please describe:  |