**Family Caregiver Support Program: *Eligibility Form***

**This form must be completed by a qualified professional such as a Doctor, Licensed Nurse or Social Worker.**

**Caregiver:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Care-Receiver:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Family Caregiver Support Program offers caregivers a chance to receive much-needed respite. It is a program funded under the Older Americans Act; through Federal and State Respite funding and a partnership with the Alzheimer’s Association.

**To be eligible, the care-receiver must have substantial deficits in their activities of daily living or have a medical diagnosis of Alzheimer’s, dementia or a related disorder.**

Indicate the care-receiver’s level of assistance needed:

**Substantial Human Assistance**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ADLs** | **0**  **(No Help)** | **1** | **2** | **3** | **4** | **5**  **(Total Dependence)** |
| Walking / Mobility |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |
| Toilet Use |  |  |  |  |  |  |
| Transferring |  |  |  |  |  |  |
| Bathing |  |  |  |  |  |  |
| Personal Grooming |  |  |  |  |  |  |
| **Continence** | | | | | | |
| Bladder |  |  |  |  |  |  |
| Bowel |  |  |  |  |  |  |

Due to a cognitive or other mental impairment, does the care-receiver require substantial supervision to maintain their health and safety? (Circle One): **YES NO**

**Significant Health Problems / Primary Diagnosis**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician / Healthcare Professional Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency Contact Number**