

GTB Family Caregiver Support Program

Caregiver Information

Last Name	First Name	Middle Initial
Address	City & State	Zip
Phone Number	Date of Birth	Tribal ID #
Signature	Date	

Elder or Grandchildren Information

Last Name	First Name	Middle Initial
Address (or same as above)	City & State	Zip
Phone Number	Date of Birth	Tribal ID #
Signature	Date	

Mark all activities for which client requires assistance				
Activities of Daily Living <input type="checkbox"/> None <input type="checkbox"/> All		Instrumental Activities of Daily Living <input type="checkbox"/> None <input type="checkbox"/> All		
MUST CHECK OFF ATLEAST		<input type="checkbox"/> Shopping	<input type="checkbox"/> Cooking Meals	<input type="checkbox"/> Doing Laundry
TWO TO QUALIFY FOR PROGRAM		<input type="checkbox"/> Light Cleaning	<input type="checkbox"/> Reheating Meals	<input type="checkbox"/> Keeping Appts.
<input type="checkbox"/> Eating	<input type="checkbox"/> Toileting	<input type="checkbox"/> Heavy Cleaning	<input type="checkbox"/> Using Phone	<input type="checkbox"/> Heating Home
<input type="checkbox"/> Dressing	<input type="checkbox"/> Bladder Function	<input type="checkbox"/> Finances	<input type="checkbox"/> Taking Medication	
<input type="checkbox"/> Bathing	<input type="checkbox"/> Bowel Function	<input type="checkbox"/> Using Public		
<input type="checkbox"/> Walking	<input type="checkbox"/> Wheeling	Transportation		
<input type="checkbox"/> Stair Climbing	<input type="checkbox"/> Transferring	<input type="checkbox"/> Using Private		
<input type="checkbox"/> Bed Mobility	<input type="checkbox"/> Mobility Level	Transportation		

Has the Care Recipient authorized this Caregiver to serve as their representative? Yes No
 Would you like to receive the Caregiver monthly newsletter? Yes No
 Would you authorize photo's to be advertised in the newsletter? Yes No

Client Cognitive and Behavioral Indicators

<p>Memory</p> <p>A. Short-term memory OK seems/appears to recall after 5 minutes.</p> <p><input type="checkbox"/> Memory OK <input type="checkbox"/> Memory is a problem</p> <p>B. Long-term memory OK- seems/appears to recall long past:</p> <p><input type="checkbox"/> Memory OK <input type="checkbox"/> Memory is a problem</p>	<p>Cognitive Skills for Daily Decision-Making</p> <p>How well person makes decisions about organizing the day, e.g. when to get up and have meals, which clothes to wear or activities to do.</p> <p><input type="checkbox"/> Independent - decisions consistently reasonable</p> <p><input type="checkbox"/> Modified independent - some difficulty in new situations</p> <p><input type="checkbox"/> Moderately impaired - decisions poor cues/supervision required.</p> <p><input type="checkbox"/> Severely impaired - never/rarely made decisions.</p>
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<p>Behavioral Symptoms</p> <p>In the last 7 days, instances when the client exhibited the following behavioral symptoms. If exhibited, ease of altering the symptom when it occurred.</p> <p>0 - Did not occur in the last 7 days 1 - Occurred, easily alter 2 - Occurred, not easily alter</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">A. Wandering (moves with no rational purpose, seemingly oblivious to needs or safety)....</td> <td style="width:10%; text-align: center;"><input type="checkbox"/> 0</td> <td style="width:10%; text-align: center;"><input type="checkbox"/> 1</td> <td style="width:10%; text-align: center;"><input type="checkbox"/> 2</td> </tr> <tr> <td>B. Verbally abusive behavioral symptoms (threatens, screams at, curses at others)....</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> </tr> <tr> <td>C. Physically abusive behavioral symptoms (hits, shoves, scratches, sexually abuses others.)....</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> </tr> <tr> <td>D. Socially inappropriate/disruptive behavioral symptoms (disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption)</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> </tr> <tr> <td>E. Aggressive resistance to care (throws medications, pushes caregiver)</td> <td style="text-align: center;"><input type="checkbox"/> 0</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> </tr> </table>	A. Wandering (moves with no rational purpose, seemingly oblivious to needs or safety)....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	B. Verbally abusive behavioral symptoms (threatens, screams at, curses at others)....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	C. Physically abusive behavioral symptoms (hits, shoves, scratches, sexually abuses others.)....	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	D. Socially inappropriate/disruptive behavioral symptoms (disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	E. Aggressive resistance to care (throws medications, pushes caregiver)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
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Client Health and Support Services History

<p>For What Type(s) of Illness Does the Client Regularly Take Medications? (Mark all that apply)</p> <p><input type="checkbox"/> Heart Disease (angina, arrhythmia, coronary failure)</p> <p><input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Sore Joints or Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Pain Relief</p> <p><input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Stomach Disorders <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Anxiety, Depression <input type="checkbox"/> Anemia</p>	<p>Client Has Been Diagnosed with the Following?</p> <p><input type="checkbox"/> Dementia <input type="checkbox"/> ALS</p> <p><input type="checkbox"/> Mental Illness <input type="checkbox"/> MS</p> <p><input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's</p>
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Brief description of requested assistance:

OFFICE USE ONLY

Elder/Elder in the Home ____ SS/SSI ____ GTB Member Family Size ____ Tribal ID ____
 Income Level Range: ____ \$0-10,000 ____ \$10-20,000 ____ \$20-40,000 ____ \$40,000+