

MARC CLIENT INTAKE FORM - NATIONAL FAMILY CAREGIVER SUPPORT

Client Information

Last Name: _____ First Name: _____ MI: _____

Gender: M F DOB: ___/___/___ SSN: _____ DCN: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Living Alone: ___ Y ___ N

County: ___ Cass ___ Clay ___ Jackson ___ Platte ___ Ray ___ Other:

Marital Status: ___ Single ___ Married ___ Divorced ___ Partnered
 ___ Separated ___ Widowed (date of spouse's death): _____

Primary Language: ___ English
 ___ Spanish ___ Other:

Legal Status: ___ Responsible for Self ___ Power of Attorney ___ Guardian

Name: _____ Phone Number: _____

Eligibility: ___ Family Caregiver 60+ ___ Family Caregiver Under 60

Relationship: ___ Husband ___ Wife ___ Son/Son-in-Law
 ___ Daughter/Daughter-in-Law ___ Other Relative
 ___ Non-Relative ___ Relationship Missing

Veteran: ___ Yes ___ No Branch: _____ Discharge Date: _____

Spouse/Widow of Veteran? ___ Yes ___ No

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino	Citizenship Status
Race (mark more than one if necessary): ___ African-American ___ American Indian/Native Alaskan ___ Asian ___ Native Hawaiian/Pacific Islander ___ White ___ Other:	___ US Citizen ___ Permanent Res.

Income: ___ Subsidized/Low-Income Housing ___ Medicaid ___ SSI ___ Food Stamps
 ___ Low Income ___ Other:

Primary Emergency Contact:

Name: _____ Aware they are emergency contact? Y N

Home Number: _____ Work Phone: _____ Relationship: _____

Cell Number: _____ Email: _____

Address: _____ City: _____ Zip: _____

Second Emergency Contact:

Name: _____ Aware they are emergency contact? Y N

Home Number: _____ Work Phone: _____ Relationship: _____

Cell Number: _____ Email: _____

Address: _____ City: _____ Zip: _____

Referral Information				
<input type="checkbox"/> Abuse/Neglect	<input type="checkbox"/> Adult Day Care	<input type="checkbox"/> Advocacy	<input type="checkbox"/> Animal Services	<input type="checkbox"/> Case Mgmt
<input type="checkbox"/> Caregiver Services	<input type="checkbox"/> Property Tax Credit	<input type="checkbox"/> Disabilities	<input type="checkbox"/> Funeral	<input type="checkbox"/> Health Centers
<input type="checkbox"/> Hearing	<input type="checkbox"/> Home Health	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Home Repairs	<input type="checkbox"/> Home Del. Meals
<input type="checkbox"/> Housing Options	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Mental Hlth Svcs.	<input type="checkbox"/> Ombudsman	<input type="checkbox"/> Personal Care
<input type="checkbox"/> Senior Center	<input type="checkbox"/> Transportation	<input type="checkbox"/> Veterans	<input type="checkbox"/> Vision	
<input type="checkbox"/> Other:				

Nutritional Status		
	Yes	Comment
I have an illness or condition that made me change the kind/amount of food I eat.	2	
I eat fewer than 2 meals per day.	3	
I eat few fruits, vegetables, or milk products.	2	
I have 3 or more drinks of beer, liquor, or wine almost everyday.	2	
I have tooth or mouth problems that make it hard for me to eat.	2	
I don't always have enough money to buy the food I need.	4	
I eat alone most of the time.	1	
I take 3 or more different prescribed or over-the-counter drugs a day.	1	
Without wanting to, I have gained or lost 10 pounds in the past 6 months	2	Change:
I am not always physically able to shop, cook or feed myself.	2	Which:
Total score for each Yes response		Risk level:
(0-2: low risk; 3-5 moderate risk; 6 or more high risk)		

Client Signature	Date
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Intake Worker Signature	Date
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Referral Source:	Telephone Number:
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Provider:	Service:	Service Area:
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Notes:

Caregiver Name: _____

Additional Caregiver Information

Caregiver is: ___ Employed Full-Time ___ Employed Part-Time ___ Student
 ___ Unemployed ___ Retired ___ Other:

- 1. Does the caregiver have any informal supports? o Yes o No
- 2. Check limitations or constraints of primary caregiver.

___ No particular constraint ___ Poor relationship with care recipient
___ Poor health, disabled, frail ___ Lives at a distance
___ Employed ___ Alcohol, drug abuse
___ Lacks knowledge, skills ___ Financial strain
___ Providing care to others ___ Dependent on care recipient for housing, money or other
___ Not reliable due to other commitments

3. Have your job or social life been affected by your caregiver duties? o Yes o No If yes, how? _____

4. How many hours a day do you have available to provide care to this care recipient? _____

5. How many hours a day do you usually spend providing care to this care recipient? _____

6. Overall, how stressed do you feel in caring for the care recipient? (If caregiver is somewhat stressed or very stressed then complete Caregiver Stress Interview.) Check one:
o Not Stressed o Somewhat Stressed o Very Stressed

Notes:

Care Recipient Information

Last Name: _____ First Name: _____ MI: _____

Gender: M F DOB: ___/___/___ SSN: _____ DCN: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ Permanent Address: Y N Living Alone: Y N

County: ___ Cass ___ Clay ___ Jackson ___ Platte ___ Ray ___ Other:

Marital Status: ___ Single ___ Married ___ Divorced ___ Partnered Primary Language: ___ English
 ___ Separated ___ Widowed (date of spouse's death): ___ Spanish ___ Other:

Legal Status: ___ Responsible for Self ___ Power of Attorney ___ Guardian

Name: _____ Phone Number: _____

Care Recipient Lives: ___ With Caregiver ___ Near Caregiver ___ Long Distance