AAA-1244A FORFF (6-14)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Aging and Adult Services

RESET

CAREGIVER ASSESSMENT TOOL (CAT)

☐ PRE-SERVICE ☐ POST-SERVICE ☐ ENROLL ☐ CLOSE	ASSESSMENT DATE	DAARS ID NO.

PART I: INTAKE INFORMATION

A. Caregiver Profile

FIRST NAME	LAST NAME	M.I.	SOC. SEC. NO.	DATE OF BIRTH

PHONE NO. 1	PHONE NO. 2
☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER	☐ HOME ☐ WORK ☐ CELL ☐ FAX ☐ CAR ☐ OTHER
HOME OR RESIDENCE ADDRESS *(No., Street, Apt. No., City, State, ZIP)*	MAILING ADDRESS *(P.O. Box, Street, City, State, ZIP)*
VALID DATES From To	VALID DATES From To
E-MAIL ADDRESS 1 ☐ OFFICE ☐ PERSONAL ☐ WORK	E-MAIL ADDRESS 2 ☐ OFFICE ☐ PERSONAL ☐ WORK

B. Demographics

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined to state

RACE
- ☐ Asian
- ☐ Black/African American
- ☐ Hawaiian Islander or other Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other
- ☐ Declined to state

RELATIONSHIP STATUS
- ☐ Divorced
- ☐ Domestic partner
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Declined to state

LANGUAGE
- ☐ English
- ☐ American Indian (w/Eng)
- ☐ American Indian (w/o Eng) *(specify)*:_____
- ☐ Spanish (w/Eng)
- ☐ Spanish (w/o Eng)
- ☐ Other *(specify)*: _____
- ☐ Declined to state

ENGLISH FLUENCY
- ☐ Fluent
- ☐ Limited
- ☐ Needs translation
- ☐ Declined to state

EDUCATION
- ☐ Grade school or less
- ☐ Some high school
- ☐ High school graduate
- ☐ Post high school
- ☐ College degree
- ☐ Declined to state

RESIDENCE TYPE
- ☐ Apartment
- ☐ Assisted living facility
- ☐ Board and care
- ☐ DD group home
- ☐ Foster care
- ☐ House
- ☐ Mobile
- ☐ Nursing home
- ☐ Other (specify): _____
- ☐ Declined to state

LIVING ARRANGEMENT
- ☐ N/A
- ☐ No pay
- ☐ Owns
- ☐ Rents
- ☐ Subsidized
- ☐ Declined to state

NUMBER IN HOUSEHOLD

HOUSEHOLD COMPOSITION
- ☐ Institutionalized
- ☐ Lives alone
- ☐ With domestic partner
- ☐ With non-relative(s)
- ☐ With other relative(s)
- ☐ With parent(s)
- ☐ With spouse
- ☐ Other *(specify)*: _____
- ☐ Declined to state

LENGTH OF TIME AT PRESENT ADDRESS

_____Years _____Months

URBAN/RURAL
- ☐ Rural
- ☐ Urban
- ☐ Declined to state

SEX / GENDER
- ☐ Female
- ☐ Male
- ☐ Unknown

TRANSGENDER *(optional)*
- ☐ Yes
- ☐ No
- ☐ Declined to state

SEXUAL ORIENTATION *(optional)*
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Declined to state

VETERAN
- ☐ No
- ☐ Child
- ☐ Spouse
- ☐ Veteran
  Veteran #_____
- ☐ Declined to state

CAREGIVER'S NAME	DAARS ID#

PART II: ASSESSMENT

A. Caregiver/Care Recipient Information

Are you the primary unpaid caregiver of a family member or loved one? ..... ☐ Yes ☐ No

CARE RECIPIENT'S NAME *(Last, First, M.I.)*	GENDER	DATE OF BIRTH	SOC. SEC. NO.
	☐ Female ☐ Male ☐ Unknown		

ADDRESS (No., Street, City, State, ZIP)

CARE RECIPIENT ELIGIBILITY CATEGORY	RELATIONSHIP OF CAREGIVER TO CARE RECIPIENT		LENGTH OF TIME PROVIDING CARE
☐ 60 and over	☐ Husband	☐ Son/Son-in-law	☐ Less than 1 year
☐ Alzheimer's disease	☐ Wife	☐ Grandparent	☐ 1-2 years
☐ Age 18 – 59 with a disability	☐ Domestic partner	☐ Other relative	☐ 3-5 years
☐ Kinship child under 19	☐ Daughter/Daughter-in-law	☐ Non-relative	☐ 6-10 years
			☐ 11 or more years

Does the caregiver reside with the care recipient? ..... ☐ Yes ☐ No

B. Caregiver Status

MEDICAL STATUS	EMOTIONAL STATUS	MONTHLY INCOME
☐ Good	☐ Good	☐ $0 - $1,000
☐ Fair	☐ Fair	☐ $1,001 - $1,500
☐ Poor	☐ Poor	☐ $1,501 - $2,000
		☐ $2,001 - $2,500
		☐ $2,501 - Above
		☐ Not available

CONDITIONS AFFECTING CAREGIVER

☐ Alzheimer's or related dementia	☐ Cancer	☐ Diabetes
☐ Heart problems	☐ Paralysis/stroke	☐ Parkinson's disease
☐ Frailty due to aging	☐ Stress	☐ Anxiety
☐ Depression	☐ Physical disability/injury	☐ Other
☐ None		

C. Overall Assessment

Assessor, in your judgment, how well does existing caregiver(s) meet the needs of the client?	Assessor, in your judgment, do you expect the caregiver's ability to meet the client's needs to:	Assessor, in your judgment, what is the overall stress level for existing caregiver(s) in meeting the client's needs?
☐ Excellent	☐ Increase	☐ Low
☐ Adequate	☐ Remain same	☐ Moderate
☐ Inadequate	☐ Decrease slightly	☐ High
	☐ Decrease substantially	

D. Domain Assessment *(Respite Services Only)*

Instructions

This assessment is only required in conjunction with an authorization for respite services, but can be used in other situations as deemed appropriate by the case manager. The following statements may be helpful in preparing the caregiver for the assessment process:

- This caregiver assessment is required in situations where respite services are being authorized to allow you to take a break from your duties caring for your loved one. This assessment is done prior to you receiving respite services, and again after you have received services for a year. This is done to determine if and how your situation has changed since you enrolled, and to measure how the respite services may have impacted you and your loved one.
- For most of these questions, there is no right or wrong answer. You might even think some questions are odd or don't fit you or your situation. Please try to choose the best answer for you. We simply need your opinions, thoughts and feelings about each area we will cover, so please answer each question as honestly as possible.
- I want to thank you for taking the time to answer these questions. They help us provide and continue to improve our services. Your responses really do count!

CAREGIVER'S NAME	DAARS ID#

CAREGIVER RISKS

Caregiving Activities/Responsibilities and Impact

*Assessor: "*I'd like to begin by asking you about some of the tasks, problems and challenges you may have encountered while caring for CR *[care recipient; insert relationship or name as appropriate]* during the last month."

IADL / ADL / Continence: Within the past month, you mentioned CR needed help with the following types of problems *[refer to ASCAP, Part IV- BASIC FUNCTIONAL ASSESSMENT, Section C, Assessment of Daily Living Activities responses]*:

1.1 Is it hard or stressful for you to help CR with these problem(s)?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Unknown
- ☐ Refused
- ☐ N/A

List the two activities needing the most assistance:

1. _____ 2. _____

1.2 In the **past six months** have you seen any improvement overall in these problems *[listed in 1.1]*? If no, was there a change or decline? *[then probe for substantially or minimally as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Unknown
- ☐ Refused
- ☐ N/A

Behavioral Challenges *including cognitive functioning, orientation, behaviors, and communication/sensory***:** Within the past month, you mentioned CR needed help with the following types of problems *[refer to responses from ASCAP, Part IV- BASIC FUNCTIONAL ASSESSMENT, Section A, Orientation and Section B, Communication/Sensory, and/or ASCAP Part V, ADDITIONAL FUNCTIONAL ASSESSMENT, Section D: Behaviors]*:

1.3 Is it hard or stressful for you to help CR with these problem(s)?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Unknown
- ☐ Refused
- ☐ N/A

List the two activities needing the most assistance:

1. _____ 2. _____

1.4 In the **past six months** have you seen any improvement overall in these problems *[listed in 1.3]*? If no, was there a change or decline? *[then probe for substantially or minimally as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Unknown
- ☐ Refused
- ☐ N/A

CAREGIVER'S NAME	DAARS ID#

Mental Health/Behavioral Health: Within the past month, you mentioned CR needed help with the following types of problems *[refer to responses from ASCAP, Part V- ADDITIONAL FUNCTIONAL ASSESSMENT, Section C, Mental/Behavioral Health. If no Part V responses are available, list the top two Mental/Behavioral Health conditions of which care recipient displays symptoms, e.g., anxiety, depression, suicidal behavior, etc.]*:

1.5 Is it hard or stressful for you to help CR with these problem(s)?

- ☐ Never
- ☐ Sometimes
- ☐ Often
- ☐ Unknown
- ☐ Refused
- ☐ N/A

List the two activities needing the most assistance:

1. _____ 2. _____

1.6 In the **past six months** have you seen any improvement overall in these problems *[listed in 1.5]*? If no, was there a change or decline? *[then probe for substantially or minimally as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Unknown
- ☐ Refused
- ☐ N/A

Physical Health

*Assessor: "*Now I would like to ask you a few questions about *your* physical health."

2.1 In general, would you say your current physical health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know
- ☐ Declined to answer

2.2 In the **past six months** do you feel your physical health has improved, declined or stayed the same? *[Probe for substantially or minimally, as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Don't know
- ☐ Declined to answer

Stress/Strain/Mood/Burden

Assessor: "Caregivers (family and friends) are often so concerned with caring for their loved one's needs that they lose sight of their own well-being. Thinking about yourself, within the past month, have you…"

3.1	Felt cut off from your family and friends?	☐ No	☐ Yes
3.2	Felt overwhelmed?	☐ No	☐ Yes
3.3	Had trouble falling asleep, staying asleep, or waking up too early?	☐ No	☐ Yes
3.4	Noticed your eating habits worsen as a result of your caregiving?	☐ No	☐ Yes
3.5	Been frustrated or angry as a result of your caregiving?	☐ No	☐ Yes
3.6	Often felt sad or depressed?	☐ No	☐ Yes
3.7	Often felt nervous or anxious?	☐ No	☐ Yes
3.8	Had crying spells or felt like you often needed to cry?	☐ No	☐ Yes

3.9 On a scale of 1 to 10, with 1 being "not stressful" and 10 being "extremely stressful," please rate your current level of stress. _____

CAREGIVER'S NAME	DAARS ID#

Assessor: "Now I am going to ask some questions regarding your feelings about caring for CR *[Probe for never, rarely, sometimes, quite frequently, or nearly always, as needed.]*

	Never	Rarely	Some-times	Quite Frequently	Nearly Always	Unknown	Refused
3.10 Do you feel stressed between caring for CR and trying to meet other responsibilities (work/family)?	☐	☐	☐	☐	☐	☐	☐
3.11 Do you feel strained when you are around CR?	☐	☐	☐	☐	☐	☐	☐
3.12 Have you felt like screaming or yelling at CR because of the way he/she behaved?	☐	☐	☐	☐	☐	☐	☐

3.13 In the **past six months** do you feel your emotional well-being and stress level has improved, declined or stayed the same? *[Probe for substantially or minimally, as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Don't know
- ☐ Declined to answer

Assessor: "Family caregivers use a variety of ways to cope or help manage stress related to their caregiving responsibilities. Sometimes when we are experiencing a lot of stress, we can find ourselves using medications (including those over the counter), smoking a cigarette or having an alcoholic beverage in response to that stress." *[Probe for never, rarely, sometimes, quite frequently, or nearly always, as needed.]*

	Never	Rarely	Some-times	Quite Frequently	Nearly Always	Unknown	Refused
3.14 In the **past month**, how often have you found yourself taking medications or drugs (including OTC medications), smoking, or drinking alcohol to help you handle stress related to your caregiving activities and responsibilities?	☐	☐	☐	☐	☐	☐	☐

3.15 In the **past six months** would you say that this frequency (using medication, smoking, drinking, etc.) has increased, declined or stayed the same? *[Probe for substantially or minimally, as needed]*

- ☐ Increased substantially
- ☐ Increased minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Don't know
- ☐ Declined to answer

Informal Social Support

4.1 Which of the following best describes the situation under which you typically provide care?

- ☐ I am the only person who provides any substantial amount of care
- ☐ I provide most of the care
- ☐ I share care responsibilities about equally with others
- ☐ I provide less care than other family members or friends
- ☐ Unknown
- ☐ Refused

Assessor: "I would like to ask you some more questions about your relationships with others, especially as they relate to your caregiving responsibilities. When I use the term someone or others, it includes friends, neighbors or family members. I would like you to think about these questions in regard to your caregiving responsibilities or activities." *[Probe for not at all, a little, or a lot, as needed.]*

	Not at all	A little	A lot	Don't know	Declined Answer
4.2 In the past month, how satisfied have you been overall with getting guidance, emotional support and physical help from friends and family with regard to your caregiving activities and responsibilities?	☐	☐	☐	☐	☐
4.3 With regard to your caregiving activities and responsibilities, how often in the past month have others made too many demands on, been critical of or taken advantage of you?	☐	☐	☐	☐	☐
4.4 In the past month, how upset overall are you about the times people did this (that is, placed demands on, criticized or took advantage of you)?	☐	☐	☐	☐	☐

CAREGIVER'S NAME	DAARS ID#

4.5 In the **past six months** do you feel your satisfaction with help and support that you receive from others has improved, declined or stayed the same? *[Probe for substantially or minimally, as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Don't know
- ☐ Declined to answer

Pleasant Activities/Leisure Time Satisfaction

		Not at all	A little	A lot	Don't know	Declined Answer
5.1	In the past month, how often have you been able to spend time on the activities that you enjoy (e.g., going to religious services, socializing with others, going out for a meal) or on hobbies or activities you like to enjoy alone (e.g., reading, gardening)?	☐	☐	☐	☐	☐
5.2	How satisfied are you with the overall amount of time you have been able to spend on the activities that you enjoy (e.g., going to religious services, socializing with others, going out for a meal) or on hobbies or activities you like to enjoy alone (e.g., reading, gardening)?	☐	☐	☐	☐	☐

5.3 In the **past six months** do you feel your satisfaction with the overall amount of time you have been able to spend in pleasurable activities has improved, declined or stayed the same? *[Probe for substantially or minimally, as needed]*

- ☐ Improved substantially
- ☐ Improved minimally
- ☐ Stayed the same or about the same
- ☐ Declined minimally
- ☐ Declined substantially
- ☐ Don't know
- ☐ Declined to answer

E. Post-Service Evaluation *(Respite Services Only)*

*Instructions – **Only administered after service delivery.***

This final set of questions asks about the caregiver's experiences RECEIVING RESPITE SERVICES. The following statements may be helpful in preparing the caregiver for the assessment process:

- Your feedback is one of the most effective ways we have of developing future services and programs for people caring for family members or friends with memory or health problems.
- Before we begin, I want to remind you that all of the information you give me will be kept confidential, and if you are uncomfortable with a question, you can refuse to answer it. If you don't understand a question, please feel free to ask me to repeat it or clarify it. You can stop this portion of the interview at any time, but please remember that the more information you can give us, the better we can help caregivers like you in the future.
- We want your honest feedback about your experiences, your feelings, and your opinions about the respite services you received. None of your responses will affect your relationship with our programs and services in any way.
- Do you have any questions before we begin? *(Note to assessor: CR = care recipient; insert relationship or name as appropriate).*

		Not at all	Some	A great deal	Don't know	Declined Answer
6.1	Overall, how much to you think you benefited from receiving respite services [Assessor may need to describe services]?	☐	☐	☐	☐	☐
6.2	How much did receiving respite services help you feel more confident in providing care for CR?	☐	☐	☐	☐	☐
6.3	How much did receiving respite services help make your life easier?	☐	☐	☐	☐	☐
6.4	How much did receiving respite services help enhance your ability to care for CR?	☐	☐	☐	☐	☐
6.5	How much did receiving respite services help improve CR's life?	☐	☐	☐	☐	☐
6.6	How much did receiving respite services help keep CR living at home with you?	☐	☐	☐	☐	☐

CAREGIVER'S NAME	DAARS ID#

PART VII: SERVICE ENROLLMENTS

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

☐ OPEN ☐ CHANGE ☐ CLOSE ☐ CONTINUE	PROVIDER / SUBCONTRACTOR	PROVIDER CODE
SCOPE OF WORK	PROGRAM	SERVICE DETAIL
ENROLLMENT STATUS ☐ Enrolled ☐ Disenrolled ☐ Waitlisted	CLOSURE REASON	LOCATION *(Optional)*
AUTHORIZATION PERIOD (mm/dd/yy) From: Through:	COST SHARE AMOUNT PER UNIT/MONTH	COST SHARE OPTION ☐ Total ☐ Rate
QUANTITY	UNITS	FREQUENCY/PERIOD ☐ One time ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:
COMMENTS		

CAREGIVER'S NAME	DAARS ID#

PART III: AUTHORIZATION

Authorization / Autorización

Select service(s) needed that is not authorized through the Area Agency on Aging. For each service selected, indicate whether the service is not available or if there is a wait list, if applicable. If none, select "None".

_____ I have received a copy of the Client Rights and Responsibilities and I certify by my signature or mark that I understand my rights and responsibilities, and that the information provided on this form, as it relates to my request and eligibility, is true and correct.

He recibido una copia del folleto, Derechos y Responsabilidades del Cliente y atestiguo por mi firma o marca que entiendo mis derechos y responsabilidades y que la información provista en este formulario como se relaciona a mi petición y mi elegibilidad es verdadera y correcta.

_____ The service plan has been discussed with me and I agree with the described services. I have received a copy of the grievance and appeals procedure, and I understand that if I disagree with any action taken in my case, I have the right to present a verbal or written request for a fair hearing.

Me han explicado el plan de servicios y estoy de acuerdo con los servicios descritos. He recibido una copia del procedimiento de quejas y entiendo que si no estoy de acuerdo con cualquiera acción tomado en mi caso, que yo tengo el derecho a presentar una solicitud verbal o por escrito de una audiencia imparcial.

_____ I was provided the opportunity to contribute voluntarily to the cost of services.

Se me proporcionó la oportunidad de contribuir de manera voluntaria al costo de los servicios.

_____ _____
Client's Signature or Mark / *Firma o marca del cliente* Date / *Fecha*

_____ _____ _____
Responsible Party's Signature / *Firma del parte responsable* Relationship / *Afinidad* Date / Fecha

_____ _____
Worker's Signature / *Firma del trabajador* Date / *Fecha*