CALIFORNIA CAREGIVER RESOURCE CENTERS
UNIFORM ASSESSMENT TOOL

Directions: Substitute the care receiver's name for [CR].

I. PROCEDURAL DATA

A. CRC Site Code #:___ ___ Client Code# : ___ ___ ___ ___ ___

B. CRC Staff Name: _____ Staff Code #: ___ ___ ___ ___

C. Date of Assessment: ___ ___ / ___ ___ / ___ ___
M M D D Y Y

II. INTRODUCTORY QUESTION TO THE CAREGIVER

Please briefly describe your current caregiving situation.

_____

_____

III. SUPPORT/LIVING SITUATION

A. Are other family members or friends involved in the care of [CR]? *(If yes, check all that apply.)* If family or friends are involved, how are they working together to provide care for [CR]?

_____

_____

(A) Check all that apply.
Friends _____
Neighbors _____
Spouse/partner___
Children _____
Parents _____
Siblings _____
Other _____

B. Who provides you with emotional support? *(Check all that apply.)*

_____

_____

(B) Check all that apply.
Friends _____
Coworkers _____
Spouse/partner___
Children _____
Parents _____
Siblings _____
Religious/Spiritual __
Support Group __
Counseling _____
Other _____

C. How many HOURS PER WEEK do YOU provide care, assistance, supervision or companionship to [CR]? (Not to exceed 168 hours) _____ HOURS/WEEK

D. On average, how many HOURS PER WEEK of PAID help do you receive? (Excluding residential care; including adult day care, home attendant care, etc.)

_____ HOURS/WEEK

E. On average, how many HOURS PER WEEK of UNPAID help do you receive from family, friends, or volunteers? _____ HOURS/WEEK

F. Think of the help you get from all your family and friends in looking after [CR]. Please identify the one response that most closely identifies your help situation: *(Circle only one.)*

1. I receive no help
2. I receive far less help than I need
3. I receive somewhat less help than I need
4. I receive about what I need in terms of help
5. I don't need any help

IV. FUNCTIONAL LEVEL OF THE CARE RECEIVER: *Ask regardless of placement status.*

Does [CR] currently have problems with the following activities?	NO	YES	DON'T KNOW N/A	COMMENTS
A. Eating	0	1	9	
B. Bathing/showering	0	1	9	
C. Dressing (choosing/putting on appropriate clothing)	0	1	9	
D. Grooming (brushing hair, teeth)	0	1	9	
E. Using the toilet	0	1	9	
F. Incontinence	0	1	9	
G. Transferring from bed/chair/car	0	1	9	
H. Preparing meals	0	1	9	
I. Staying alone, must be supervised	0	1	9	
J. Taking medications	0	1	9	
K. Managing money or finances	0	1	9	
L. Performing household chores	0	1	9	
M. Using the telephone	0	1	9	
N. Mobility	0	1	9	
O. Wandering, or the potential to wander	0	1	9	

P. Which functional problems cause you the most concern in caring for [CR]?

_____

_____

Q. Does [CR] still drive? No Yes

a. If YES, do you have concerns? What are they? _____

b. If YES, do you know the Department of Motor Vehicles (DMV) and medical reporting guidelines? No Yes

V. MEMORY AND BEHAVIORAL PROBLEMS

Family Consultant: Please hand the Revised Memory and Behavior Problems Checklist to the caregiver for him/her to complete (located on pages 9-11). If the caregiver is unable to complete unassisted, please read the checklist and responses to the caregiver and record his/her responses. After the caregiver has completed the RMBPC, review the form and select the problems that cause the caregiver the most upset to discuss in the following question.

A. You have indicated that _____ cause(s) you concern. Please tell me more about [CR's] difficulties and your individual concerns.

_____

VI. HEALTH

A. Does [CR] have health insurance? 0. No 1. Yes If yes, what type?_____

B. Does [CR] have prescription drug coverage? ..... 0. No 1. Yes

C. What is the annual out-of-pocket expense for prescription drugs for [CR]? $_____

D. Does [CR] have California Advance Health Care Directive? ..... 0. No 1. Yes

E. Do you have health insurance? 0. No 1. Yes If yes, what type?_____

F. Do you have prescription drug coverage? ..... 0. No 1. Yes

G. What is the annual out-of-pocket expense for prescription drugs for you? $_____

H. Do you have California Advance Health Care Directive? ..... 0. No 1. Yes

I. How would you rate your overall health at this time?

1. Excellent 2. Good 3. Fair 4. Poor

J. Is your health now better, about the same, or worse than it was 6 months ago?

1. Better 2. About the same 3. Worse

K. How often in the past 6 months have you had a medical examination or received treatment for physical health problems from a health care practitioner? _____ times

L. Please indicate which of the following health problems you have experienced in the past 12 months. (*Circle all that apply.)*

1) Allergies	7) High cholesterol	12) Blood pressure level	17) Broken bone/osteoporosis
2) Arthritis	8) Dental	13) Respiratory/asthma	18) Cardiovascular disease/ heart trouble
3) Back/neck	9) Diabetes	14) Stomach	19) Gynecological/menopausal
4) Blood/liver/kidney	10) Eyes/ears/nose	15) Sleep disturbance	20) Thyroid/endocrinology
5) Bowel	11) Infectious disease	16) Weight	21) Headaches/migraines
6) Cancer	22) Other_____		23) None

M. Have you experienced anxiety or depression in the past 12 months? 0.No 1.Yes

a. If YES, please describe your experience. _____

_____

b. If YES, have you received help? What type? Was the intervention helpful?

_____

_____

c. If YES, do you currently have thoughts about suicide? If YES, do you have a plan?

_____

If YES, then follow the Suicide Protocol contained in the Operations Manual.

N. How much does your health stand in the way of your doing the things you want to do?

0. Not at all 1. A little 2. Moderately 3. Very much

O. When under stress, caregivers sometimes find that their drinking and/or drug use increases. Is that a concern for you? Has someone you know expressed that concern for you?

_____

_____

P. If you are currently taking prescription medication, are you experiencing difficulties managing your medications (overuse, under-use, adverse effects, etc.)?

_____

_____

Q. In addition to caregiving, have you recently had a major stress in your life such as a death, job loss, or divorce?

_____

_____

VII. ADAPTED ZARIT INTERVIEW *(Bédard et al. 2001)*

Family Consultant: Please read the Adapted Zarit Interview exactly as it is written in order to maintain the validity of the scale. Do not hand the paper to the caregiver to complete. See the Instruction Manual for further directions.

DO YOU FEEL…	**NEVER**	**RARELY**	**SOMETIMES**	**QUITE FREQUENTLY**	**NEARLY ALWAYS**
A. …that because of the time you spend with [CR] that you don't have enough time for yourself?	0	1	2	3	4
B. …stressed between caring for [CR] and trying to meet other responsibilities (work/family)?	0	1	2	3	4
C. …angry when you are around the care receiver?	0	1	2	3	4
D. …that [CR] currently affects your relationship with family members or friends in a negative way?	0	1	2	3	4
E. …strained when you are around [CR]?	0	1	2	3	4
F. …that your health has suffered because of your involvement with [CR]?	0	1	2	3	4
G. …that you don't have as much privacy as you would like because of [CR]?	0	1	2	3	4
H. …that your social life has suffered because you are caring for [CR]?	0	1	2	3	4
I. …that you have lost control of your life since [CR]'s illness?	0	1	2	3	4
J. …uncertain about what to do about [CR]?	0	1	2	3	4
K. …you should be doing more for [CR]?	0	1	2	3	4
L. …you could do a better job in caring for [CR]?	0	1	2	3	4
					_____/

VIII. OTHER CAREGIVING ISSUES AND PLACEMENT

A. *(Optional)* Sometimes a person who is caregiving experiences changes in his/her personal or intimate relationships, as a result of caregiving. Are there relationship issues you would like to discuss?

_____

_____

B. Would you consider moving [CR] to a facility? What issues might cause you to seriously consider placement? *(e.g. incontinence, aggression, wandering, falls, your physical health or exhaustion, financial or emotional strain)*

_____

_____

IX. CAREGIVER AND CARE RECEIVER DEMOGRAPHICS

A. In what year did you begin caregiving? _____

B. Are you currently employed?

1. Full-time (35 hours/week or more)
2. Part-time (less than 35 hours/week)
3. Leave of absence
4. Not Employed
5. Retired

C. Has your employment status changed <u>because of caregiving duties</u>? (*Circle all that apply.)*

1. No change
2. Changed jobs
3. Family/medical leave
4. Leave of absence
5. Increased hours
6. Decreased hours
7. Early retirement
8. Began working
9. Quit job
10. Laid off
11. Other

D. What is your highest level of education?

1. Less than high school
2. Some high school
3. High school graduate
4. Some college coursework
5. College graduate
6. Post-graduate degree
7. Declined to state

E. What is your current marital status?

1. Married
2. Separated
3. Divorced
4. Widowed
5. Living together/domestic partners
6. Single

F. What is <u>your annual household</u> income level? *(Include income of all persons in the household who share expenses.)*

1. Under $9,000
2. $9,000 – $11,999
3. $12,000 – $19,999
4. $20,000 – $39,999
5. $40,000 – $59,999
6. $60,000 – $79,999
7. $80,000 – $99,999
8. $100,000 or above
9. Caregiver declined to state

G. What is <u>[CR's] and spouse's</u> (when applicable) annual income level? *(Not household income: exclude the income of other individuals even if they live in the same household. DO NOT LEAVE BLANK: if the same as the previous question, please circle again.)*

1. Under $9,000
2. $9,000 – $11,999
3. $12,000 – $19,999
4. $20,000 – $39,999
5. $40,000 – $59,999
6. $60,000 – $79,999
7. $80,000 – $99,999
8. $100,000 or above
9. Caregiver declined to state

H. Does someone hold durable power of attorney for finances for [CR]? 0.No 1.Yes

If YES, what is his/her relationship with [CR]? _____

I. Please identify any additional caregiving responsibilities for other people that may apply.

1. Dependent minor(s) without disability
2. Dependent minor(s) with disability
3. Adult(s) without disability *(e.g. frail elder)*
4. Adult(s) with disability

X. INFORMATION NEEDS

A. How knowledgeable do you feel about [CR's] disease/disorder?
0. Not at all 1. A little 2. Moderately 3. Very

B. How familiar are you with programs/resources available to help you?
0. Not at all 1. A little 2. Moderately 3. Very

Do you need information about:	NO	YES
C. …education or training classes on how to care for yourself as a caregiver?	0	1
D. …education or training classes on how to care for [CR]?	0	1
E. …community resources, such as a meal-delivery service or a transportation service?	0	1
F. …finding someone to help to take care of [CR] during the day in his/her home or about short-term respite in a facility?	0	1
G. …about a camp for [CR] or a retreat for you?	0	1
H. …adult day programs that [CR] could attend?	0	1
I. …legal and financial issues related to caregiving (e.g. durable power of attorney, living will, trusts, legal guardian/conservator, etc.)?	0	1
J. …helping you plan for the care of [CR], such as financial benefits and long term care planning (e.g. Medi-Cal, Social Security, IHSS, etc.)?	0	1
K. …placing [CR] in an assisted living or skilled nursing facility?	0	1
L. …the opportunity to talk with a group of people who are in a similar situation, such as a support group?	0	1
M. …professional counseling options?	0	1
N. …online caregiving information sites and support groups?	0	1

XI. CARE PLAN: PLAN OF ACTION BY CRC STAFF

For each type of service, write the number of the service code or codes that apply to the caregiver's plan of action. More than one service code may apply for a type of service. If the type of service is not listed, use rows 22-24 and write the type of service in the Comments column.

SERVICE CODES

1. CRC provided service (1658 funds)
2. CRC provided service (non-1658 funds)
3. Waitlist
4. External referral
5. Referral refused
6. Service needed but not available
7. Already receiving service

TYPE OF SERVICE	SERVICE CODE(S)	COMMENTS
1. Follow-Up Info & Referral		
2. Family Consultation		
3. Counseling: Individual		
4. Support Group		
5. Psychoeducational Group		
6. Education/Training		
7. Geriatric/Medical Evaluation		
8. Neuropsychological Consultation		
9. Legal/Financial Consultation		
10. Respite: Adult Day Care		
11. Respite: In-home		
12. Respite: Out-of-home		
13. Caregiver Retreat		
14. Respite: Camp for care receiver		
15. Transportation		
16. Link2Care		
17. Case Management		
18. Home Health Services		
19. Hospice		
20. Home Maker/Chore Worker		
21. Help with Placement		
22. Other (Specify under Comments)		
23. Other (Specify under Comments)		
24. Other (Specify under Comments)		

V. MEMORY AND BEHAVIORAL PROBLEMS *(Teri et al. 1992)*

The following is a list of problems care receivers sometimes have. Please indicate if any of these problems have occurred during the past week. If so, how much has this bothered or upset you when it happened? Use the following scales for the frequency of the problem and your reaction to it. Please read the description of the ratings carefully.

FREQUENCY
Indicate if any of these problems occurred during the past week.

If your response is one of the three shaded responses below, please report your reaction.

REACTION
If the problem has occurred in the past week, how much has this bothered or upset you when it happened?

	Don't Know N/A	Never occurred	Not in the past week	1 to 2 times	3 to 6 times	Daily or more often	Don't Know N/A	Not at all	A little	Moderately	Very Much	Extremely
1. Asking the same question over and over.												
2. Trouble remembering recent events (e.g., items in the newspaper or on TV).												
3. Trouble remembering significant past events.												
4. Losing or misplacing things.												
5. Forgetting what day it is.												
6. Starting but not finishing things.												
7. Difficulty concentrating on a task.												
8. Destroying property.												

FREQUENCY
Indicate if any of these problems occurred during the past week.

If your response is one of the three shaded responses below, please report your reaction.

REACTION
If the problem has occurred in the past week, how much has this bothered or upset you when it happened?

	Don't Know N/A	Never occurred	Not in the past week	1 to 2 times	3 to 6 times	Daily or more often	Don't Know N/A	Not at all	A little	Moderately	Very Much	Extremely
9. Doing things that embarrass you.												
10. Waking you or other family members up at night.												
11. Talking loudly and rapidly.												
12. Appears anxious or worried.												
13. Engaging in behavior that is potentially dangerous to self or others.												
14. Threats to hurt oneself.												
15. Threats to hurt others.												
16. Aggressive to others verbally.												
17. Appears sad or depressed.												

FREQUENCY
Indicate if any of these problems occurred during the past week.

If your response is one of the three shaded responses below, please report your reaction.

REACTION
If the problem has occurred in the past week, how much has this bothered or upset you when it happened?

	Don't Know N/A	Never occurred	Not in the past week	1 to 2 times	3 to 6 times	Daily or more often	Don't Know N/A	Not at all	A little	Moderately	Very Much	Extremely
18. Expressing feelings of hopelessness or sadness about the future (e.g.," Nothing worthwhile ever happens," "I never do anything right").												
19. Crying and tearfulness.												
20. Commenting about death of self or others (e.g., "Life isn't worth living," "I'd be better off dead").												
21. Talking about feeling lonely.												
22. Comments about feeling worthless or being a burden to others.												
23. Comments about feeling like a failure or about not having any worthwhile accomplishments in life.												
24. Arguing, irritability, and/or complaining.												
						____/						____/

XII. CAREGIVER QUESTIONNAIRE *(Radloff 1977)*

Below is a list of the ways you (the caregiver) may have felt or behaved recently. For each statement, check the box that best describes how often you have felt this way during the *past week*.

DURING THE PAST WEEK:	Rarely or None of the Time (Less than 1 day)	Some of the Time (1-2 days)	Occasionally (3-4 days)	Most of the Time (5-7 days)
A. I was bothered by things that don't usually bother me.	☐	☐	☐	☐
B. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
C. I felt that I could not shake the blues even with help from my family and friends.	☐	☐	☐	☐
D. I felt that I was just as good as other people.	☐	☐	☐	☐
E. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
F. I felt depressed.	☐	☐	☐	☐
G. I felt that everything I did was an effort.	☐	☐	☐	☐
H. I felt hopeful about the future.	☐	☐	☐	☐
I. I thought my life had been a failure.	☐	☐	☐	☐
J. I felt fearful.	☐	☐	☐	☐
K. My sleep was restless.	☐	☐	☐	☐
L. I was happy.	☐	☐	☐	☐
M. I talked less than usual.	☐	☐	☐	☐
N. I felt lonely.	☐	☐	☐	☐
O. People were unfriendly.	☐	☐	☐	☐
P. I enjoyed life.	☐	☐	☐	☐
Q. I had crying spells.	☐	☐	☐	☐
R. I felt sad.	☐	☐	☐	☐
S. I felt that people disliked me.	☐	☐	☐	☐
T. I could not get "going."	☐	☐	☐	☐

____/