Arizona Department of Economic Security
Division of Aging and Adult Services



# Caregiver Assessment Tool (CAT)

☐ Pre-Service ☐ Post-Service ☐ Enroll ☐ Close

Assessment Date: _____ DAARS ID No. : _____

## Part I: Intake Information

### A. Caregiver Profile

Name *(Last, First, M.I.)*: _____ Date of Birth: _____

Phone No. 1: _____ ☐ Home ☐ Work ☐ Cell ☐ FAX ☐ Other

Home or Residence Address *(No., Street, Apt. No., City, State, ZIP)*:

_____

Valid Dates From: _____ To: _____

E-Mail Address 1: _____

☐ Office ☐ Personal ☐ Work

Phone No. 2: _____ ☐ Home ☐ Work ☐ Cell ☐ FAX ☐ Car ☐ Other

Mailing Address *(P.O. Box, Street, City, State, ZIP)*:

_____

Valid Dates From: _____ To: _____

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

See page 11 for EOE/ADA disclosures/*Vea la página 8 para leer la declaración de EOE/ADA*

Caregiver's Name: _____ DAARS ID No. :_____

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 of People 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

Urban/Rural: ☐ Rural ☐ Urban ☐ Declined to state

Sex/Gender: ☐ Female ☐ Male ☐ Unknown

Transgender (optional): ☐ Yes ☐ No ☐ Declined to state

Veteran:

☐ No ☐ Child ☐ Spouse ☐ Veteran Veteran #:_____ ☐ Declined to state

## 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: ☐ Female ☐ Male ☐ Unknown

Date of Birth: _____ Soc. Sec. No.: _____

Care Recipient Eligibility Category:

☐ 60 and over ☐ Alzheimer's disease ☐ Age 18 – 59 with a disability
☐ Kinship child under 19

Relationship of Caregiver to Care Recipient:

☐ Husband ☐ Wife ☐ Domestic partner ☐ Daughter/Daughter-in-law
☐ Son/Son-in-law ☐ Grandparent ☐ Other relative ☐ Non-relative

Length of Time Providing Care:

☐ Less than 1 year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 11 or more years

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

### B. Caregiver Status

Medical Status: ☐ Good ☐ Fair ☐ Poor Emotional Status: ☐ Good ☐ Fair ☐ Poor

Monthly Income:

☐ $0 - $1,000 ☐ $1,001 - $1,500 ☐ $1,501 - $2,000 ☐ $2,001 - $2,500 ☐ $2,501 - Above

Caregiver's Name: _____ DAARS ID No. :_____

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

**C. Overall Assessment**

Assessor, in your judgment, how well does existing caregiver(s) meet the needs of the client?

☐ Excellent ☐ Adequate ☐ Inadequate

Assessor, in your judgment, do you expect the caregiver's ability to meet the client's needs to:

☐ Increase ☐ Remain same ☐ Decrease slightly ☐ Decrease substantially

Assessor, in your judgment, what is the overall stress level for existing caregiver(s) in meeting the client's needs?

☐ Low ☐ Moderate ☐ High

**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 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 _____ 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]*:

Caregiver's Name: _____ DAARS ID No. :_____

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

**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

Caregiver's Name: _____ DAARS ID No. :_____

**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 ☐ Unknown ☐ Refused ☐ N/A

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

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 _____

*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.]*

3.10 Do you feel stressed between caring for CR and trying to meet other responsibilities (work/family)?

☐ Never ☐ Rarely ☐ Sometimes ☐ Quite Frequently ☐ Nearly Always

☐ Unknown ☐ Refused

3.11 Do you feel strained when you are around CR?

☐ Never ☐ Rarely ☐ Sometimes ☐ Quite Frequently ☐ Nearly Always

☐ Unknown ☐ Refused

3.12 Have you felt like screaming or yelling at CR because of the way he/she behaved?

☐ Never ☐ Rarely ☐ Sometimes ☐ Quite Frequently ☐ Nearly Always

☐ Unknown ☐ Refused

Caregiver's Name: _____ DAARS ID No. :_____

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 ☐ Unknown ☐ Refused ☐ N/A

*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.]*

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?

☐ Never ☐ Rarely ☐ Sometimes ☐ Quite Frequently ☐ Nearly Always
☐ Unknown ☐ Refused

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]*

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

**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.]*

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?

☐ Not at all ☐ A little ☐ A lot ☐ Don't know ☐ Declined answer

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?

☐ Not at all ☐ A little ☐ A lot ☐ Don't know ☐ Declined answer

Caregiver's Name: _____ DAARS ID No. :_____

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)*?

☐ Not at all ☐ A little ☐ A lot ☐ Don't know ☐ Declined answer

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 ☐ Unknown ☐ Refused ☐ N/A

**Pleasant Activities/Leisure Time Satisfaction**

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)*?

☐ Not at all ☐ A little ☐ A lot ☐ Don't know ☐ Declined answer

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)*?

☐ Not at all ☐ A little ☐ A lot ☐ Don't know ☐ Declined answer

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 ☐ Unknown ☐ Refused ☐ N/A

## 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)*.

6.1 Overall, how much to you think you benefited from receiving respite services *[Assessor may need to describe services]*?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

Caregiver's Name: _____ DAARS ID No. :_____

6.2 How much did receiving respite services help you feel more confident in providing care for CR?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

6.3 How much did receiving respite services help make your life easier?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

6.4 How much did receiving respite services help enhance your ability to care for CR?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

6.5 How much did receiving respite services help improve CR's life?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

6.6 How much did receiving respite services help keep CR living at home with you?

☐ Not at all ☐ Some ☐ A great deal ☐ Don't know ☐ Declined answer

## Part III: 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: _____

Caregiver's Name: _____ DAARS ID No. :_____

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

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☐ 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

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☐ Open ☐ Change ☐ Close ☐ Continue

Provider/Subcontractor: _____

Caregiver's Name: _____ DAARS ID No. :_____

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

## Part IV: 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.*

Caregiver's Name: _____ DAARS ID No. :_____

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*: _____