BLUEGRASS AREA AGENCY ON AGING
GRANDPARENT AND OLDER RELATIVE
CAREGIVER SELF ASSESSMENT

Grandparent/Relative's Name: _____ Date: ____/____/____

Child or Grandchild's Name(s):

Name: _____ Age: _____ School: _____

Name: _____ Age: _____ School: _____

Name: _____ Age: _____ School: _____

Caregiver's Date of Birth: ____/____/____ Caregiver's Gender: Male Female
(Circle One)

Race: _____ Rural or Non-Rural Above or Below Poverty
(Circle One) (See Attached – Circle One)

Relationship to Child(ren): Grandparent _____
Great Aunt or Uncle _____
Great-Grandparent _____
Great-Aunt or Great-Uncle _____
Other Relative _____

Does caregiver work outside the home? Yes____ No____ Hours per week: _____

How do you rate your own health? Excellent____ Good____ Fair____ Poor____

How long have you been a caregiver for this child(ren)? _____

How many hours per week do you spend caregiving? _____

What type of day to day care do you provide? _____

_____

_____

Of these activities, which have proved most difficult to manage? _____

_____

What are/have been the consequences of your care responsibilities?

Difficulties in getting out____
Difficulties in getting personal time for leisure____
Difficulties in meeting work or financial obligations_____
Difficulties in finding help from other relatives____
Difficulties in finding help from public/social services____
Difficulties in other social/personal relationships____
Difficulties in maintaining personal health____

What kind of support do you receive from family or friends?

Day-to-day care support____
Psychological support____
Information or decision-making support____
Temporary respite/sitter support____
Errands or household support____
Financial management support____

What kind of formal support do you receive with the care of your grandchild(ren)?

____ Family Resource Center
____ First Steps
____ CCSHCN
____ IMPACT
____ K-CHIP
____ SSI
____ KFCP
____ Comprehensive Care Services
____ KY Assistive Technology
____ EPSDT
____ IMPACT Plus
____ Medicaid
____ SSDI
____Kinship Care

Other(s) – Please List _____

Please list any areas in which you would like more resource information:

____ Public Benefits **____ Legal and Custody** **____ Parenting**

____ Grief and Loss **____ Substance Abuse** **____ Difficult Behaviors**

____ Activities **____ Other _____**

Please add anything else here that you think is important for us to know about you and your caregiving situation:

_____

_____