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 (Circle One)    Above or Below Poverty
      (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  ____ Comprehensive Care Services
____ First Steps  ____ KY Assistive Technology
____ CCSHCN  ____ EPSDT
____ IMPACT  ____ IMPACT Plus
____ K-CHIP  ____ Medicaid
____ SSI  ____ SSDI
____ KFCP  ____ 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:

________________________________________________________________________
________________________________________________________________________