The Respite Center
Admissions Application

Today's Date: _____

Part I: Information about the Caregiver

Caregiver's Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

Parish: _____ Gender: ☐Male ☐Female

Caregiver EMAIL: _____

Caregiver's Marital Status: ☐Single ☐Married/Domestic Partner ☐Widowed ☐Other _____

Caregiver's Date of Birth: _____

Caregiver's Race:
☐White
☐African-American
☐American Indian or Alaska Native
(principal tribe_____)
☐Asian (race:_____)
☐Pacific Islander (race: _____)

Caregiver's Fluent languages:
☐English ☐Spanish ☐French ☐Other: _____

Caregiver's Employment status:
☐Works full-time
☐Works part-time
☐Retired; works part-time
☐Retired
☐Homemaker
☐Unemployed
☐Other _____

What is the highest grade in school that the caregiver completed?
☐8th grade or less
☐Attended high school
☐High school graduate (diploma or GED)
☐Some college or post high school training
☐Associate Degree
☐Bachelor's Degree
☐Graduate degree or higher

Caregiver's relationship to client/elder
☐no caregiver identified ☐spouse/domestic partner ☐child/child-in-law ☐sibling
☐other relative ☐friend/neighbor ☐professional care manager ☐other:_____

Part II. Information about Client/Care Receiver

Client Name _____ Social Security No._____

Address_____

City _____ State _____ Zip_____ Phone _____

Parish: _____ Gender: ☐Male ☐Female

Client Marital Status: ☐Single ☐Married/Domestic Partner ☐Widowed ☐Other _____

Date of Marriage: _____ Client/Elder's Date of Birth: _____

Client Height _____Client Weight _____Color of Eyes_____ Color of Hair_____

Client is ☐ Right-Handed ☐ Left-Handed Is Client a Veteran/Spouse of Veteran Y N

Physician Name: _____ Physician Phone: _____

Client's Race:
☐White
☐Black, African-American or Negro
☐American Indian or Alaska Native
(principal tribe_____)
☐Asian (race:_____)
☐Pacific Islander (race: _____)

Client's Fluent languages:
☐English
☐Spanish
☐French
☐Other, list: _____

Physician's diagnosis (select one)
☐Dementia
☐Alzheimer Disease
☐Pick's Disease
☐Mild Cognitive Impairment
☐Lewy Body Dementia
☐Vascular
☐Frontal Temporal Lobe Dementia
☐Parkinson's
☐Other related disorder,
explain_____
☐Has not been diagnosed; Alzheimer's or other dementia is suspected

Approximate year of diagnosis: _____

Approximate date caregiver first noticed client/elder having memory problems: _____

Which stage did the physician say the client is in or do you think he/she is in:

☐**Stage I: Mild**	☐**Stage II: Moderate**	☐**Stage III: Severe**
Repeating themselves	Confused about recent events	Inability to understand words
Getting lost in familiar places	Not recognizing self in mirror	Difficulty with simple tasks
Losing interest in hobbies	Not recognizing family	Arguing frequently
Forgetting common items	Unable to care for self	Believing things are real that are not
Losing things more often	Anxiety and/or depression	Repetitive actions or speech
Personality change		

Where does the client reside?

☐Lives alone in house or an apartment.

How many people including client/elder live in house/apartment?_____

☐Lives in house or apartment with others.

How many people including client/elder live in house/apartment? _____

☐Lives in a group environment with assistance (not a nursing home)

☐Lives in nursing home

☐Other _____

Does the client live with the primary caregiver? ☐Yes ☐No

Geographic location of client's residence :

☐rural or farm community (fewer than 2,500)

☐small city or town that is not suburb of a larger city (2,500 – 50,000)

☐medium city or suburb of a medium city (50,000 – 100,000)

☐large city or suburb of a large city (100,000 plus)

☐Indian reservation

☐Other: _____

PART III. Respite Center Enrollment.

Who referred you to the Alzheimer's Services Respite Center? _____

How much help, if any, does the client need with each of these activities?

	Needs no help/supervision	Needs some help/occasional supervision	Needs a lot of help/constant supervision	Can't do it at all
Eating	☐	☐	☐	☐
Getting in and out of bed	☐	☐	☐	☐
Getting around inside	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Using the toilet	☐	☐	☐	☐
Doing heavy housework	☐	☐	☐	☐
Doing light housework	☐	☐	☐	☐
Doing laundry	☐	☐	☐	☐

Cooking/preparing meals	☐	☐	☐	☐
Buying/getting food/clothes	☐	☐	☐	☐
Getting around outside	☐	☐	☐	☐
Going places outside of walking distance	☐	☐	☐	☐
Managing money	☐	☐	☐	☐
Taking medicine	☐	☐	☐	☐
Using telephone	☐	☐	☐	☐

In a typical week, how many hours total did the caregiver help client with:

	hours per week
Eating, bathing, dressing or helping with toilet functions	_____
Meal preparation, laundry or light housework	_____
Providing transportation to appointments and/or shopping	_____
Legal matters, banking or money matters	_____

Which of the following services are the client and/or family currently using? (Check *ALL* services that are used by either the client/elder *OR* the caregiver)

☐Companion or friendly visitor
☐Supervision
☐Homemaker services
☐Chore services
☐Personal care services
☐Home health services
☐Adult daycare center/adult day health
☐Respite in a nursing home, adult foster home, or someone else's home
☐Transportation services
☐Case management
☐Support groups
☐Caregiver training program
☐Psychological counseling
☐Group meals/home delivered meals
☐Other service: _____

CONTINUE TO NEXT PAGE

Client Behavioral Information

For the following questions, check yes or no. Briefly explain or expand upon answers, as needed, in the space provided.

Is the client manageable for you at home at this time? ☐Yes ☐No

---

At home, does the client/elder have problems with:

a. sleep patterns: ☐Yes ☐No

---

b. eating habits: ☐Yes ☐No

---

c. mobility: ☐Yes ☐No

---

d. wandering: ☐Yes ☐No

---

e. incontinence: ☐Yes ☐No

---

f. level of anxiety: ☐Yes ☐No

---

g. level of cooperation: ☐Yes ☐No

---

h. level of contentment: ☐Yes ☐No

---

i. expressions of happiness: ☐Yes ☐No

---

j. other (e.g., change in medication): ☐Yes ☐No

Using the following scale, please rate the client's present day level of loneliness, helplessness, and boredom by circling the number of the best description for each.

	None of the time	Some of the time	All of the time
Loneliness	1	2	3
Helplessness	1	2	3
Boredom	1	2	3

Client Health and Demographic Information

Number and type of chronic diseases or physical impairments he/she has (check all that apply):

☐None ☐arthritis
☐diabetes ☐hypertension
☐heart disease ☐other _____

Number of visits by the doctor he/she has had in the past 12 months:

☐none ☐4 to 6
☐1 to 3 ☐over 6

Number of hospital stays he/she has had in the past 12 months:

☐none ☐4 to 6
☐1 to 3 ☐over 6

Number of physician prescribed medications he/she is currently taking:

☐1 to 4 ☐5 to 8 ☐over 9

Does the client use any of the following appliances or aids? (check all that apply)

☐Wheelchair ☐Cane ☐Walker ☐Hearing Aid (☐right ☐left) ☐Eyeglasses
☐Dentures (☐upper ☐lower)

Does the client have difficulty with food, eating or swallowing?

☐No ☐ Yes Please describe: _____

Does the client follow a special diet?

☐No ☐ Yes Please describe: _____

Does the client have any allergies? (Includes food, drugs and environment)

☐Drugs: _____
☐Pollen ☐Eggs ☐Sulfa ☐Dairy Products ☐Insect Bites
☐Other: _____

Future Directions
What other information would be helpful to you?

Please rate your interest in attending an educational workshop on each the following topics:

	No Interest	A little	A great deal
Incontinence care	1	2	3
Adaptive equipment (clothing, special utensils, etc)	1	2	3
Nutrition and dietary concerns	1	2	3
Managing problem behavior	1	2	3
Other _____	1	2	3