

UPPER ARKANSAS AREA AGENCY ON AGING

* PRIMARY CAREGIVER INTAKE RECORD

Date _____

| | | | |
|------------------|-------------------|---|------------|
| Last Name: | First Name | Middle Initial: | Birthdate: |
| Maiden Name: | Social Security # | <input type="checkbox"/> Male <input type="checkbox"/> Female | Age: |
| Nickname: | Race: | Telephone: Home: Work or Cell: | |
| Mailing Address: | City: | State: | Zip Code: |

| |
|---|
| Name of person receiving care _____ |
| Your relationship to person receiving care _____ |
| Number of hours this person needs assistance each week _____ |
| Number of hours care you provide to care receiver each week _____ |

SERVICES REQUESTED: Caregiver Respite _____ Caregiver Counseling _____

Caregiver Educational Materials _____ Caregiver Information _____

Other Services (Please Specify) _____

While there is no fee for the services you receive from the Area Agency on Aging, we would like for you to know that our agency relies heavily on contributions from our clients, enabling us to continue to provide services to the community. If you feel you are able to contribute to this vital program, any amount that you can contribute is greatly appreciated. A suggested contribution would be from 5% to 20% of the amount you have allotted for services.

I hereby affirm that the information above is a true and accurate record of the hours of care I provide to the care receiver.

Applicants Signature _____ Date _____

*** Primary Caregiver is the person responsible for the majority of caregiving duties.**

Area Agency on Aging
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