

TITLE III E FAMILY CARE RECEIVER-CAREGIVER – FY 2026-27

CONFIDENTIAL

CONTRACTOR:				DATE:	
CARE RECEIVER'S INFORMATION					
Last Name:				First Name: (No nicknames)	
Phone:				Birth Date: (Required)	
Street Address:				City:	ZIP:
County:		Rural: (91307, 93066, 93040)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined/no stated	
RACE/ETHNICITY – CHECK ALL THAT APPLY (X):					
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian		<input type="checkbox"/> Hawaiian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Middle Eastern or North African		<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race/Ethnicity <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Declined/no stated	
MARITAL STATUS:		<input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Widowed <input type="checkbox"/> Declined/no stated			
VETERAN STATUS: <input type="checkbox"/> I consent to this agency and the California Department of Aging transmitting my name, email address, and mobile telephone number to the Department of Veterans Affairs only for the purpose of receiving additional information on veterans benefits for which I may be eligible. I understand that this consent is valid for 12 months. Contact the California Department of Veterans Affairs (CalVet) to determine eligibility for services and support at www.calvet.ca.gov or 1-800-952-5626.		<input type="checkbox"/> Have you ever served in the United States military? <input type="checkbox"/> Are you the spouse, legal partner, parent, or child of a person who is serving in or who has served in the United States military? <input type="checkbox"/> No <input type="checkbox"/> Declined/no stated		Preferred Language:	
Client Lives:		<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined/no stated			
		Number of Persons Living in Household:			
INDICATE CARE RECEIVER'S INCOME LEVEL (approximate):					
IF Single Household: <input type="checkbox"/> At or below Federal Poverty Level (\$15,960/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$15,961/year or more) <input type="checkbox"/> Declined/no stated			IF Married Household: <input type="checkbox"/> At or below Federal Poverty Level (\$21,640/year or less) <input type="checkbox"/> Above Federal Poverty Level (\$21,641/year or more) <input type="checkbox"/> Declined/no stated		
The Gay Bisexual and Transgender Disparities Reduction Act of 2016 (AB 959)					
The State of CA requires that we ask you some demographic questions followed by three questions under the new CA State AB 959 Law, the Gay, Bisexual and Transgender Disparities Reduction Act of 2016. VCAA values your privacy and you have the option to decline state.					

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What was the Care Receiver's sex at birth?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Declined/no stated
What is the Care Receiver's Gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Genderqueer/Gender Non-binary <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Not listed, please specify: _____
How do you describe Care Receiver's sexual orientation or sexual identity?	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay/Lesbian/Same-Gender Loving <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Declined/not stated <input type="checkbox"/> Not listed, please specify: _____

CALIFORNIA ACTIVITIES & INSTRUMENTAL ACTIVITIES (IADLS) OF DAILY LIVING (ADLS)							
Please Check (✓) One of the Columns for Each Activity							
TYPE OF ASSISTANCE CARE RECEIVER NEEDS TO PERFORM TASK →	1 INDEPENDENT Needs No Help	2 VERBAL QUE Needs verbal reminders	3 STAND BY Needs some human help	4 HANDS ON Needs lots of human help	5 DEPENDENT Cannot perform task	Decline to State	
A D L S	Eating						
	Dressing						
	Transferring						
	Bathing						
	Toileting						
Walking							
I A D L S	Light Housework						
	Shopping/Errands						
	Meal Prep/Cleanup						
	Transportation						
	Using Telephone						
	Managing Medications						
	Managing Money						
	Heavy Housework						
Care Receiver's Cognitive Impairment:	<input type="checkbox"/> None or Unknown <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe						

CARE RECEIVER'S LIVING ARRANGEMENT: <input type="checkbox"/> With you (caregiver) <input type="checkbox"/> Alone in his/her home/apartment <input type="checkbox"/> With spouse or partner <input type="checkbox"/> In a board and care home, group home, assisted living facility or RCFE <input type="checkbox"/> Nursing home <input type="checkbox"/> Retirement community <input type="checkbox"/> In home of other family member/friend <input type="checkbox"/> Other <input type="checkbox"/> Unknown

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Client Lives:			<input type="checkbox"/> Alone <input type="checkbox"/> Not Alone <input type="checkbox"/> Declined/no stated		Number of Persons Living in Household:
Applicant's Income Level (approximate):					
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Relationship with Care Receiver:	
<input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Daughter-in-law <input type="checkbox"/> Son-in- law <input type="checkbox"/> Other Relative <input type="checkbox"/> Non-Relative <input type="checkbox"/> Declined/no stated	
Caregiver's Employment:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Declined/no stated <input type="checkbox"/> Not employed (unemployed) <input type="checkbox"/> Retired
Narrative/Case Notes (Optional):	
Reviewed By:	Number of Hours:
Client LiveWell Database/Unique Participant ID Number:	