BEAUMONT HEALTH – BEAUMONT GERIATRIC CENTER
FAMILY/CAREGIVER CHECKLIST

As part of the Geriatric Clinic services, a social worker is available to meet with you to review any of the following. **Please complete and check all the items you would like to discuss. Please do not write in shaded areas.**

Patient Name:_____ Patient DOB:_____

Name of person(s) filling out this form:_____

Relationship to patient:_____

Living Arrangements:

Which of the following best describes the patient's residence? (Check one)

- ☐ Apartment
- ☐ Condominium
- ☐ House
- ☐ Mobile Home
- ☐ Assisted Living Residence
- ☐ Other: _____

Does the patient: ☐ Pay rent ☐ Pay mortgage ☐ Own/no current cost

Does the patient employ someone to provide care or assistance in their home?

- ☐ No
- ☐ Yes ☐ How many ____ hours/day ____ days/week

Is this sufficient to meet your needs? ☐ No ☐ Yes

Does the patient get help from family members or friends in their home?

- ☐ No
- ☐ Yes ☐ How many ____ hours/day ____ days/week

Is this sufficient to meet your needs? ☐ No ☐ Yes

Does the patient provide care or assistance for a family member or friend?

- ☐ No
- ☐ Yes, describe: _____

Finances:

Which of the following best describes the patient's financial status?

- ☐ Comfortably able to afford all necessities (food, clothing, housing, transportation, medications)
- ☐ Able to afford necessities with careful budgeting
- ☐ Barely able to afford basic needs
- ☐ Unable to afford the necessities

Please check box next to all current sources of income for the patient:

- ☐ Social Security
- ☐ SSI
- ☐ Pension
- ☐ Savings
- ☐ Investments
- ☐ Salary (Paycheck)

Does the patient receive any additional assistance to meet their financial needs?

- ☐ No
- ☐ Yes (check those that apply):
  - ☐ From family/friends
  - ☐ Food Stamps
  - ☐ Medicaid
  - ☐ Other: _____

Patient Name: _____

Insurance/Prescription Coverage:

Please check all insurances you have.

□ Medicare □ MediGap (supplemental, ex. Blue Cross, AARP)
□ Medicaid □ Other: _____

Do you have prescription coverage from your insurance?

□ No □ Yes; Amount of co-pay: _____

ISSUES: Please Check all that apply

A. Management of care recipient behavior

__ Refusal of help
__ Excessive dependency
__ Withdrawal from meaningful activity
__ Expression of anger/depression
__ Unsafe behavior (i.e. driving, wandering, hitting)
__ Use of alcohol
__ Other (Please Specify): _____

B. Management of family issues:

__ Lack of/limited assistance from other family members
__ Lack of consensus as to how to handle care needs/provide assistance
__ Other (Please Specify): _____

C. Difficulties related to caregiving

__ Inability to take time off from caregiving
__ Conflicting demands between caregiving and family/job/personal duties
__ Emotional/physical cost of caregiving
__ Other (Please Specify): _____

D. Alternative care options:

__ In-home care services (housekeeper, personal care assistant sitter)
__ Senior residential (assisted) living
__ Adult foster care
__Nursing home care
__ Other (Please Specify): _____

__ Dementia packet given	OFFICE USE ONLY
__ Depression packet given	
__ Memory tips given	
__ Community Resource Guide given	
__ Helping Hands Brochure given	
__ Other:	

Patient Name: _____

Please circle all you would like to discuss (Please do not write in shaded areas):

TOPICS	**INFORMATION GIVEN/REFERRAL MADE** (OFFICE USE ONLY)
1. Adult Day Care	
2. Senior Citizen Center	
3. Transportation	
4. Senior companion	
5. Emergency alert systems	__Lifeline Brochure given __Other:
6. Senior housing	
7. Counseling/support group referral	
8. Handicap parking sticker	__ Application given __Other:
9. Durable Power of Attorney for Medical Decision Making	__DPOA Booklet given __Other:
10. Guardianship Conservatorship	__ Guardianship Booklet given __Other:
11. Meals on Wheels	
12. Financial assistance with medication cost	__WMR information given __Pharmaceutical Company info given __Other:
13. Medicare/insurance questions	
14. Family leave time from work	
15. Other (please specify):	