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| **Family Caregiver Survey** |

This Survey is for **unpaid family caregivers** and is used in conjunction with one-on-one consultation with a caregiver specialist from your local community.

For more information about supports and resources for caregivers, contact your local Community Living Connections Office.

To find your local office visit <https://waclc.org/familycaregiver> or call 855-567-0252.

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| Today’s Date | | |  | | |  | | | | | |  | | | |
| Caregiver Name | | | |  | | | | | | Date of Birth | | |  | | |
| Care Receiver Name | | | | |  | | | | | Date of Birth | | |  | | |
| Does the person you care for (care receiver) live with you?  Yes  No  ***If No****, what is their physical address*: | | | | | | | | | | | | | | | |
| Address | |  | | | | | | | City, State, Zip | |  | | | | |
| Caregiver Contact Information | | | | | | | | | | | | | | | |
| Phone |  | | | | | | Email |  | | | | | | | |
| Address | |  | | | | | | | City, State, Zip | |  | | | | |
| Your Mailing Address (if different than physical): | | | | | | | | | | | | | |  |  |
| Address | |  | | | | | | | City, State, Zip | |  | | | | |

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| 1. **Are you the person most responsible for caring for your care receiver\*?** | | | | | | | | |
| *\*Care receiver means any adult who needs care or supervision by an unpaid caregiver. For example, care receiver can be your spouse, partner, parent, adult child, friend, neighbor or other relative.*  Yes  No | | | | | | | | |
| **Who do you care for?** | | | | | | | | |
| Spouse | Relative Child | | | | Other Relative | | | |
| Domestic Partner | Grandchild | | | | Non-Relative | | | |
| Ex-Spouse | Grandparent | | | | Relationship’s Missing | | | |
| Parent/Parent-in-law | Other Elderly Relative | | | | Declined to state | | | |
| Sibling/Sibling In-Law | Other Elderly Non-Relative | | | | Other | | | |
| **Describe other:** | | | | | | | | |
| **Notes:** | | | | | | | | |
| 1. **The following are some thoughts and feelings that people sometimes experience when they assist their care receiver.** | | | | | | | | |
| ***Instructions:*** *Please check the box that best reflect how you feel about each of the following statements.* | | ***Strongly Disagree*** | ***Disagree*** | ***Disagree a Little*** | | ***Agree a Little*** | ***Agree*** | ***Strongly Agree*** |
| 1. I am not sure that I can accept any more responsibility than I have right now. | |  |  |  | |  |  |  |
| 1. I am not always able to be the person I want to be when I am with my care receiver. | |  |  |  | |  |  |  |
| 1. It is difficult for me to accept all the responsibility for my care receiver. | |  |  |  | |  |  |  |

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| 1. **Which of the following best describes your care receiver’s memory?** | |
| No Memory Problem | Memory or Cognitive Issue Suspected. |
| Probable Alzheimer’s disease or other dementia is suspected, but is not medically diagnosed. | Yes, Alzheimer’s disease or other dementia has been medically diagnosed. |

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| 1. **Given your care receiver’s CURRENT CONDITION, would you consider placing your care receiver in a different care setting?** | | |
| Definitely not | Probably would | Does not apply-care receiver is in care facility |
| Probably not | Definitely would |  |

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| 1. **As a result of assisting the care receiver, have the following aspects of your life changed?** | | | | | | |
| ***Instructions:*** *Read through each of the statements below and indicate how much you agree or disagree with each statement by making a check in the appropriate box.* | ***Strongly Disagree*** | ***Disagree*** | ***Disagree a little*** | ***Agree a little*** | ***Agree*** | ***Strongly Agree*** |
| 1. Have your caregiving responsibilities caused conflicts with your care receiver? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities given your life more meaning? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities increased the number of unreasonable requests made by your care receiver? |  |  |  |  |  |  |

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| 1. Have your caregiving responsibilities made you more satisfied with your relationship? |  |  |  |  |  |  |
| 1. Have your caregiving responisbilites caused you to feel that your care receiver makes demands over and above what they need? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities created a feeling of hopelessness? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities given you a sense of fulfillment? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities changed your routine? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities caused you to worry? |  |  |  |  |  |  |
| 1. Have your caregiving responsibilities left you with almost no time to relax? |  |  |  |  |  |  |

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| 1. **Below is a list of statements about the way you have felt in the past week.** | | | | |
| **Instructions:** *Please indicate how often you have felt the following* ***during the past week***. | **Rarely or none of the time (less than 1 day)** | **Some or a little of the time (1-2 days)** | **Occasionally or moderate amount of time**  **(3-4 days)** | **All of the time (5-7 days)** |
| 1. How often have you had trouble keeping your mind on what you were doing? |  |  |  |  |
| 1. How often have you felt depressed? |  |  |  |  |
| 1. How often have you felt hopeful about the future in the past week? |  |  |  |  |
| 1. How often have you had restless sleep in the past week? |  |  |  |  |

**Please Return Your Completed Survey Using an Option Below:**

* Email: [seniorinfo@kitsap.gov](mailto:seniorinfo@kitsap.gov)

An E-mail we receive from you may be subject to disclosure as a public record under the Public Records Act, RCW Chapter 42.56 and Email transmission cannot be guaranteed to be secure or error free, as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete or contain viruses.

To keep your information more secure, you have the option to call our office (360) 337-5700 to request we send you an encrypted email to use for returning your completed TCare survey as an attachment in the email. Upon receiving the email from our office, you will be asked to create a password for opening the email to attach your survey and reply.

* Fax: (360) 337-5747
* Mail: Kitsap County ALTC, 614 Division St. MS-5, Port Orchard WA 98366