



MS Dementia Care Intake Form

Please complete the following intake form for potential participation in the **Mississippi Dementia Care Program**. There are four sections to complete; this form asks you about you (the Caregiver) and the Care Recipient. The intake form should take approximately 10-15 minutes to complete. A survey follows the intake form; the survey should take about 10 minutes to complete. Only one intake form per caregiver/household can be completed. For any questions related to this program, intake form, or survey, please contact the **Dementia Care Specialist** by telephone at **(601) 359-4635** or by email at **msdementia.care@mdhs.ms.gov**.

SECTION 1. This section asks questions about you, the Caregiver.

First Name		Last Name		DOB (Month)	DOB (Day)	DOB (Year)
Mailing Address		City		State MS	Zip Code	
My community would be considered: <input type="checkbox"/> Rural (population of less than 50,000) <input type="checkbox"/> Urban (population of 50,000 or more)				County		
Telephone Number (Primary) () -		Cell Phone <input type="checkbox"/> Yes <input type="checkbox"/> No		Email Address (Primary)		
Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Separated <input type="checkbox"/> Use a different term: <input type="checkbox"/> Single				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			Minority Status <input type="checkbox"/> Minority <input type="checkbox"/> Not minority		Military Status <input type="checkbox"/> Served in military <input type="checkbox"/> Not served in military	
Race (check all that apply)						
<input type="checkbox"/> American Indian or Alaskan Native American		<input type="checkbox"/> Middle Eastern North African (MENA)				
<input type="checkbox"/> Asian or Asian American		<input type="checkbox"/> Native Hawaiian or other Pacific Islander				
<input type="checkbox"/> Black or African-American		<input type="checkbox"/> White				
<input type="checkbox"/> Prefer not to answer		<input type="checkbox"/> Some other race:				
Employment Status						
<input type="checkbox"/> Employed, working 1-39 hours (weekly)			<input type="checkbox"/> Employed, working 40 or more hours (weekly)			
<input type="checkbox"/> Not employed, looking for work			<input type="checkbox"/> Not employed, not looking			
<input type="checkbox"/> Retired			<input type="checkbox"/> Disabled, not able to work.			
Caregiving Role (Number of individuals you are actively caring for)					Annual Household Income \$	

SECTION 2. This section asks about the relationship between you and the Care Recipient.

Relationship to Care Recipient: Family member: <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Other Other member: <input type="checkbox"/> Family friend <input type="checkbox"/> Contracted helper <input type="checkbox"/> Prefer to describe: <input type="checkbox"/> No caregiver	
Number of Weekday Hours You Provide Care (average daily hours Monday-Friday)	Number of Weekend Hours You Provide Care (average daily hours Saturday-Sunday)
Typical Caregiving for this Care Patient Daily care: <input type="checkbox"/> Eating <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Mobility <input type="checkbox"/> Hygiene Care Several times weekly needs: <input type="checkbox"/> Transportation <input type="checkbox"/> Personal errands <input type="checkbox"/> Socialization	
Number of Years Providing Care for Care Patient <input type="checkbox"/> Less than a year <input type="checkbox"/> 1-2 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> 10+ years	

SECTION 3. This section asks about the Care Recipient.

First Name	Last Name	DOB (Month)	DOB (Day)	DOB (Year)
Mailing Address		City	State MS	Zip Code
My community would be considered: <input type="checkbox"/> Rural (population of less than 50,000) <input type="checkbox"/> Urban (population of 50,000 or more)		County		
Telephone Number (Primary)	Cell Phone (Y/N)	Email Address (Primary)		
Marital Status <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Prefer not to state <input type="checkbox"/> Use a different term:	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Minority Status <input type="checkbox"/> Minority <input type="checkbox"/> Not minority	Military Status <input type="checkbox"/> Served in military <input type="checkbox"/> Not served in military		
Race <input type="checkbox"/> American Indian or Alaskan Native American <input type="checkbox"/> Middle Eastern North African (MENA) <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African-American <input type="checkbox"/> White <input type="checkbox"/> Some other race:				

Disabilities & Chronic Conditions	
<input type="checkbox"/> Alzheimer's/cognitive decline	<input type="checkbox"/> Attention deficit
<input type="checkbox"/> Deaf or hard of hearing	<input type="checkbox"/> Health-related disability
<input type="checkbox"/> Mobility-related disability	<input type="checkbox"/> Speech-related disability
<input type="checkbox"/> Autism	<input type="checkbox"/> Learning disability
<input type="checkbox"/> Blind or visually impaired	<input type="checkbox"/> Intellectual disability
<input type="checkbox"/> Mental health condition	<input type="checkbox"/> Other
Health Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Household Income \$
Care Recipient Hospitalization – When was the last time? <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months	Within the last year, how often have they been admitted to a hospital? <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times
Living Arrangement	
<input type="checkbox"/> Lives alone, has an identified caregiver	<input type="checkbox"/> Lives with someone who is not a caregiver
<input type="checkbox"/> Lives alone, no identified caregiver	<input type="checkbox"/> Lives with a caregiver

SECTION 4. This section asks about the Care Plan.

Care Recipient's Diagnosis or Impairment	
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cognitive decline
<input type="checkbox"/> Dementia	<input type="checkbox"/> Other:
Needed Caregiver Supports	
<input type="checkbox"/> Financial needs	<input type="checkbox"/> Physical health needs
<input type="checkbox"/> Mental health needs	<input type="checkbox"/> Other:
Requested Services	
<input type="checkbox"/> Respite Care	<input type="checkbox"/> IDEA! Strategy
<input type="checkbox"/> Other:	<input type="checkbox"/> Respite & IDEA! Strategy

End of Intake Form

Please proceed to the next page for the Caregiver Pre-Intervention Survey.



Caregiver Pre-Intervention Survey

Please fill out the following survey for the **Mississippi Dementia Care Program**. There are four sections to complete; this form asks you about your life and how you are dealing with various elements of it. It should take approximately 10 minutes to complete. For any questions related to this program, intake form, or survey, please contact the **Dementia Care Specialist** by telephone at **(601) 359-4635** or by email at **msdementia.care@mdhs.ms.gov**.

Date today: _____ (month/day/year) **DOB:** _____ (month/day/year)

First name: _____ **Last Name:** _____

Directions: For each question, please select the appropriate response by marking or checking the box like this. or

SECTION 1. This section asks questions about your mental and physical health.

Below are listed activities that each of us do or someone does for us. Thinking over the past **3 months**, indicate to what extent you think each activity has been done **for yourself**.

	Never	Rarely	Sometimes	Usually	Always
1) Taking care of personal daily activities (meals, hygiene, laundry)	<input type="checkbox"/>				
2) Taking time to have fun with friends and/or family	<input type="checkbox"/>				
3) Receiving appropriate health care	<input type="checkbox"/>				
4) Feeling good about yourself	<input type="checkbox"/>				
5) Feeling secure about your financial future	<input type="checkbox"/>				

Over the last **2 weeks**, how often has the following occurred?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
6) Being bothered by not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Being bothered by feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8) In general, how would you rate your **physical** health?

- Poor
- Fair
- Good
- Very Good
- Excellent

SECTION 2. This section asks questions about your **stressors and burdens.**

The following is a list of statements that reflect how people sometimes feel when taking care of another person. After reading each statement, indicate how often you experience the feelings listed by checking the box that best corresponds to the frequency of these feelings.

	Never	Rarely	Sometimes	Usually	Always
9) Do you feel that because of your care recipient that you don't have enough time for yourself?	<input type="checkbox"/>				
10) Do you feel stressed between caring for your care recipient and trying to meet other responsibilities (work, home)?	<input type="checkbox"/>				

Over the **last month**, how often has the following occurred?

	Never	Rarely	Sometimes	Usually	Always
11) Being upset because of something that happened unexpectedly	<input type="checkbox"/>				
12) Feeling nervous and stressed	<input type="checkbox"/>				
13) Feeling confident about your ability to handle your personal problems	<input type="checkbox"/>				
14) Finding that you could not cope with all the things that you had to do	<input type="checkbox"/>				
15) Feeling that you were on top of things	<input type="checkbox"/>				
16) Feeling difficulties were piling up so high that you could not overcome them	<input type="checkbox"/>				

SECTION 3. This section asks questions about your **quality of life.**

During the **last month**, did you have any of the following **problems** with your work or other regular daily activities as a result of being a caregiver?

	None of the Time	A little of the Time	Some of the Time	Most of the Time	All of the Time
17) Cut down on the amount of time you spent on work or other activities	<input type="checkbox"/>				
18) Accomplished less than you would like	<input type="checkbox"/>				

How much time during the **last month** ...

	None of the Time	A little of the Time	Some of the Time	Most of the Time	All of the Time
19) Did you spend personal time away from your care recipient?	<input type="checkbox"/>				
20) How much did you feel like you were "trapped"?	<input type="checkbox"/>				
21) How much have you felt unsure about how to care for care recipient?	<input type="checkbox"/>				
22) Have you felt overwhelmed?	<input type="checkbox"/>				

To what extent do you agree with this statement?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
23) During the last month , I received all the help I needed in taking care of my care recipient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24) During the last month , I worried about the financial cost of caring for my care recipient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25) Too much of my time is spent caring for my care recipient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26) I am grateful for the time that I am able to spend with care recipient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often do you...

	Never	Rarely	Sometimes	Usually	Always
27) Feel isolated from others?	<input type="checkbox"/>				

SECTION 4. This section asks questions about any **support services** you may be using.

Please indicate whether **you** received the following services in the **last 5 months** (left column) AND if you were aware that these services were available (right column). Definitions of each of these services can be found on the next page.

Check if YOU used in the past 5 months:	Were you aware these services were available? Check if "yes"
<input type="checkbox"/> Information & Referral Services	<input type="checkbox"/>
<input type="checkbox"/> Benefits & Entitlements	<input type="checkbox"/>
<input type="checkbox"/> Education & Training	<input type="checkbox"/>
<input type="checkbox"/> Support Groups for you	<input type="checkbox"/>
<input type="checkbox"/> Counseling Services for you	<input type="checkbox"/>
<input type="checkbox"/> Care/Case Management	<input type="checkbox"/>
<input type="checkbox"/> Legal Assistance	<input type="checkbox"/>
<input type="checkbox"/> Financial Planning	<input type="checkbox"/>
<input type="checkbox"/> Household Tasks and Errands	<input type="checkbox"/>
<input type="checkbox"/> Personal/Home Care for YOU (<i>private pay/Medicaid service</i>)	<input type="checkbox"/>
<input type="checkbox"/> Medical Home Health Care for YOU (<i>Medicare benefit-homebound</i>)	<input type="checkbox"/>
<input type="checkbox"/> Adult Day Program, In-Person Engagement Activities	<input type="checkbox"/>
<input type="checkbox"/> Counseling Services for the person you support	<input type="checkbox"/>
<input type="checkbox"/> Companion/Personal/Home Care & Supervision	<input type="checkbox"/>
<input type="checkbox"/> Medical Home Health Care	<input type="checkbox"/>
<input type="checkbox"/> Overnight Help	<input type="checkbox"/>
<input type="checkbox"/> Transportation	<input type="checkbox"/>

PLWD Intervention Pre Survey

Please fill out the following survey for the **Mississippi Dementia Care Program**. There are two sections to complete; this form asks the Care Recipient (the Person Living With Dementia or Cognitive Impairment) about their life and ability to deal with various elements of it. It should take approximately 10 minutes to complete. This survey should be taken with or alongside a Caregiver. For any questions related to this survey, please contact the **Dementia Care Specialist** by telephone at **(601) 359-4635** or by email at **msdementia.care@mdhs.ms.gov**.

Date today: _____ (month/day/year) DOB: _____ (month/day/year)

First name: _____ Last Name: _____

Directions: For each question, please select the appropriate response by marking or checking the box like this. or

SECTION 1. This section asks questions about your quality of life.

How would you rate your:

	Poor	Fair	Good	Excellent
1) Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Taking care of personal daily activities (meals, hygiene, laundry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Living situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Marriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Self as a whole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) Ability to do chores around the house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Ability to do things for fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) Life as a whole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 2. This section asks questions about your any hospitalizations you might have had.

Please indicate the last time you were admitted into the hospital.

Care Recipient Hospitalization – When was the last time?	Within the last year, how often have you been admitted to a hospital?
<input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times

End of Survey.

Thank you for taking this survey.

Support Services Defined

Information & Referral Services: Programs to help identify local resources including telephone or helpline services.

Benefits & Entitlements: Specialized services and benefits to which you may be entitled given your new circumstances (e.g., Food Stamps, SSI, HEAP, SCRIE/DRIE).

Education & Training: Programs, seminars, or classes designed to help people learn more about a physical or mental impairment. This can be provided through presentations, libraries, or written materials.)

Support Groups: A peer-led group meeting designed for people dealing with memory loss and/or their family and friends.

Counseling Services: Services designed to help people deal emotionally with memory loss or other problems. Provided by a social worker, psychologist, clergy, or other type of professional.

Adult Day Program, Engagement Activities: Virtual or in person programs providing social engagement and structured activities during the day for persons with dementia. These activities may include exercise, creative projects, or social engagements on a regular or intermittent basis.

Care/Case Management: Services to help people identify their needs, learn what services are available, and arrange for services to take place. Usually involves working with a case manager.

Legal Assistance: Legal services to help with issues related to health problems; for example, help with estate planning, establishing a durable power of attorney, or writing a living will.

Financial Planning: Services to assist with health care finances and anticipating future care needs.

Household Tasks and Errands: Help given by someone with household tasks or running errands. For example, help with shopping, arranging appointments, cleaning, laundry, or cooking.

Companion/Personal/Home Care: Help given by someone to aid with responsibilities. Can include in-home services like companionship, housekeeping, or chores. May be considered 'respite'. May also include help with daily activities or personal care such as bathing, dressing, and grooming; or to provide close supervision or companionship for another person.

Medical Home Health Care: Service that provides help with home health care tasks: for example, caring for incisions, changing dressings, medication management, monitoring blood pressure, or teaching special exercises.) This service is provided by a nurse (or physical therapist) and is ordered by primary care or after a hospitalization. This can also include a privately paid service for long-term care needs.

Overnight Help: Help given by someone to provide overnight relief from care responsibilities.

Transportation: Help with transportation: getting to and from appointments such as doctor or hospital visits, or just to go shopping and run other errands.

End of Survey.

Thank you for taking this survey!

Please send both the intake form and the survey to MDHS. You may email them to msdementia.care@mdhs.ms.gov or send them through the mail to the following address:

MS Department of Human Services
MS Dementia Care Program
Division of Aging and Adult Services
200 South Lamar Street
Jackson, MS 39201