



**National Family Caregiver Support Program Sauk County**

Aging and Disability Resource Center  
505 Broadway, Room #102, Baraboo, WI 53913  
(608)355-3289 Fax: 355-4375

**Marina Wittmann**, Aging Program Coordinator  
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## National Family Caregiver Support Program Application

### YOUR (Caregiver) Information

Name \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Gender: Female Male Date of Birth \_\_\_\_\_ Lives Alone? \_\_\_ Yes \_\_\_ No

How many people live in this household (including caregiver)? \_\_\_\_\_

Race: _____ White	Ethnicity: _____ Hispanic or Latino
_____ American Indian/Alaskan Native	_____ Not Hispanic or Latino
_____ Asian	_____ Unknown
_____ Hispanic	
_____ Black/African American	
_____ Native Hawaiian/Pacific Islander	
_____ Other _____	

### Income Information (income does not determine eligibility, it is used only for data reporting)

If the caregiver is single, widowed, divorced, or separated, is their annual income below \$12,760 (or monthly income below \$1,066)? \_\_\_\_\_ Yes \_\_\_\_\_ No

If the caregiver is married, is their combined annual income below \$17,240 (or monthly income below \$1,436)? \_\_\_\_\_ Yes \_\_\_\_\_ No

### Enrollment Information

Are you or your care recipient enrolled in any of the following programs: Family Care, IRIS, Care Wisconsin, Includa, AFCSP, or other Medicaid Waiver Programs?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure

### What is your relationship to the care recipient?

_____ Husband	_____ Wife
_____ Son or Son-in-law	_____ Daughter or Daughter-in-law
_____ Other relative	_____ Non-relative

**CARE RECIPIENT Information**

Name \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Gender: Female Male Date of Birth \_\_\_\_\_ Lives Alone? \_\_\_ Yes \_\_\_ No

How many people live in this household (including care recipient)? \_\_\_\_\_

Race: \_\_\_ White Ethnicity: \_\_\_ Hispanic or Latino  
\_\_\_ American Indian/Alaskan Native \_\_\_ Not Hispanic or Latino  
\_\_\_ Asian \_\_\_ Unknown  
\_\_\_ Hispanic  
\_\_\_ Black/African American  
\_\_\_ Native Hawaiian/Pacific Islander  
\_\_\_ Other \_\_\_\_\_

Does the care recipient have a diagnosis of *Alzheimer's or Dementia*? \_\_\_ Yes \_\_\_ No

**Income Information (income does not determine eligibility, it is used only for data reporting)**

If the recipient is single, widowed, divorced, or separated, is their annual income below \$12,760 (or monthly income below \$1,066)? \_\_\_ Yes \_\_\_ No

If the recipient is married, is their combined annual income below \$17,240 (or monthly income below \$1,436)? \_\_\_ Yes \_\_\_ No

**CARE RECIPIENT ASSESSMENT OF IADLs and ADLs**

Check each of the following statements that the Care Recipient has difficulty in completing or needs help with.

**Assessment of Activities of Daily Living (ADLs)**

- Getting in and out of the bath or shower or preparing the bath, washing and drying . . . . . \_\_\_
- Dressing and undressing . . . . . \_\_\_
- Completing toilet activities and personal . . . . . \_\_\_
- Getting in and out of bed or a chair . . . . . \_\_\_
- Using utensils and eating without help . . . . . \_\_\_
- Walking up and down a flight of stairs or walking without assistance . . . . . \_\_\_

**Assessment of Instrumental Activities of Daily Living (IADLs)**

(Check if care recipient has any difficulty completing these tasks)

- Preparing own meals ..... \_\_\_\_\_
- Medication management ..... \_\_\_\_\_
- Handling bill paying, banking, ect ..... \_\_\_\_\_
- Doing heavy housework and outside chores ..... \_\_\_\_\_
- Doing light housework ..... \_\_\_\_\_
- Shopping for personal items and/or groceries ..... \_\_\_\_\_
- Traveling in a van, taxi, bus, or car ..... \_\_\_\_\_
- Answering the telephone or calling out on the telephone ..... \_\_\_\_\_

Please tell us how you, the caregiver, are planning to use respite care to reduce your stress and help you recharge to continue caring for your loved one? For example: How often will you get a break? Will you go out? Take a class? Will you stay at home and your loved one will go out with another caregiver? Who will provide the care?

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How did you inquire about the Family Caregiver Support Program?

- AddLIFE Newsletter  Newspaper
- ADRC Staff (please specify whom) \_\_\_\_\_
- Hospital/Clinic Staff (please specify) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

**I certify the information reported here is true and correct.**

\_\_\_\_\_

**Name** **Date**

Please return this application to Marina Wittmann at:  
 Aging & Disability Resource Center  
 505 Broadway Street  
 Baraboo, WI 53913  
 Or Fax: (608)355-4375



The information you are being asked to provide is needed to determine eligibility and to comply with federal reporting requirements. This information will be stored in a secure electronic database and will not be used for any other purpose. Your information will not be shared with another agency without your permission. This information will not be sold to anyone. You have the right to review your electronic record and request changes to assure accuracy. You will not be denied most services if you refuse to provide this information. If you have questions regarding this please ask the Sauk County Aging & Disability Resource Center Staff. 10/5/2020 MW