Government of the Republic of Trinidad and Tobago

Ministry of Social Development and Family Services

Geriatric Adolescent Partnership Programme (G.A.P.P)

APPLICATION FOR A CAREGIVER

(Please Complete Form in Block Letters)

1. NAME OF APPLICANT: …… Tel# ……..…….

2. ADDRESS (SPECIFIC): ……...…..……
……..……
……..……

3. NAME OF CLIENT: ……. Tel# ……...……..

4. ADDRESS (SPECIFIC): ……..……
……..……
……..……

5. DATE OF BIRTH: ……... 6. SEX: …… 7. RELIGION: ……...…..……...….

8. NO. OF PERSONS RESIDING IN HOME: ……...… NO. OF DEPENDANTS: ……..

9. AGES: ……..……....

10. MARITAL STATUS: (SINGLE, MARRIED, WIDOWED, DIVORCED): ……..……...

11. NEXT OF KIN: ……..…… Tel# ……..….

12. ADDRESS: ……..……..
……..….
……..….

13. SHORT MEDICAL HISTORY OF CLIENT:

    A. PRESENT AILMENT: ……
    ……

    B. IS CLIENT MOBILE: …….....

    C. OTHER COMMENTS: ……...
    ……...
    ……...

14. DESCRIBE BRIEFLY SERVICES REQUIRED: ……

……..

……

15. PERIOD OF SERVICE (FULL-TIME, PART-TIME): ……

16. WOULD YOU ALLOW GAPP PERSONNEL TO VISIT CLIENT'S HOME: ……..

N:B THE DURATION OF HOME HEALTH CARE SERVICE WILL BE FOR SIX (6) MONTHS. AFTER WHICH A REVIEW WILL BE CONDUCTED.

COMMUNITY HOME HEALTH CARE SERVICE

I ……. hereby certify that: -

i. The above given information is true and correct. I understand that otherwise my application will be annulled.
ii. I will comply with the GAPP Agency policies and code of conduct.
iii. Application may be deferred if the home does not meet the required standard.

PLACEMENT AGENCY

i. The above given information is true and correct. I understand that otherwise my application will be annulled.
ii. I will comply with the minimum wages and other statutory requirements.

Date …….. Signature of Application……

For Official Use

Date Application Received ……. Receiving Officer…….

Services Required ……..…… Day …… Time ……...

Community Health Care Service ☐ Placement Agency ☐

Applicant's Consecutive No. ……

Regional Co-ordinator's Stamp

NEEDS ASSESSMENT WORKSHEET

This can help the family discuss the items with which the older person needs or wants assistance. Please check which daily activities the older person is capable of accomplishing (a) alone, (b) needs assistance, or (c) cannot accomplish alone. Consult the older person.

ACTIVITIES OF DAILY LIVING (ADLs)

Activity	Accomplishes alone	Needs some help	Needs much help
Bathing			
Dressing			
Grooming			
Toileting			
Eating a nutritious meal			
Getting out of bed			
Getting out of a chair			
Walking			

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Activity	Accomplishes alone	Needs some help	Needs much help
Using the telephone			
Shopping for personal items			
Transportation			
Managing money			
Doing Laundry			
Doing light housework			
Preparing meals			

LOCATING COMMUNITY RESOURCES

Check the older person's limitations – disability or environmental barriers. Consult the older person.

Disability
How does the following affect the person's ability to function?

Limitation	No Effect	Some Effect	Major Effect
Hearing			
Vision			
Perception			
Orientation			
Grasping			
Balance			
Strength			
Energy			
Bladder or bowel control			
Physical deformity			
Depression			
Chronic sinusitis			
Arthritis			
Hypertension			
Heart Disease			
Diabetes			
Dementia/Alzheimer's			
Parkinson			
Renal Failure			
Cancer			

COMMENTS:

ELDER CARE CHOICES AND DECISIONS NEEDS ASSESSMENT WORKSHEET

Environmental barriers to daily living (handicaps)

Which barriers can be removed or changed?

Limitation	No Problem	Needs to be changed
Neighbourhood:		
➢ Safety		
➢ Convenience		
➢ Friends or relatives nearby		
Living Quarters:		
➢ Conditions		
➢ Age of the dwelling		
➢ Roof in good repair		
➢ Windows in good repair		
➢ Siding in good condition		
➢ Looks cared for		
➢ Security and safety		
➢ Deadbolt locks on outside doors		
➢ Window bars or locks		
➢ Visible from road		
➢ Passageways clear of wires and clutter		
Stairs:		
➢ Free of obstacles and clutter		
➢ Well lit		
➢ Handrails on both sides		
➢ In good repair and nonskid		

COMMENTS

- ❖ Likes to do during the day:……..
- ❖ Pets:……..
- ❖ Personal Strengths?.....
- ❖ Any other problems or issues?.....

Significant others (including family members)

Name	Relationship	Occupation	Capacity to help	Duration Power of Attorney

FINANCIAL RESOURCES:

Monthly income:

☐ 0 - $2,000 ☐ $2,001 - $6,000 ☐ $6,001 - $10,000 ☐ $10,00 +

Home Own? Yes: ☐ No: ☐ Renting? Yes: ☐ No: ☐

Are you a recipient of any other Social Service Grant?

Yes: ☐ No: ☐ Pending: ☐

If Yes, please state: - ……..

RESPONSIBILITY OF A CAREGIVER TO CLIENT

Listed below are the duties/responsibilities of caregivers where applicable

- PERSONAL HYGIENE
  (Daily Living Activities)
  Assist client with:

  1. Bathing (bed bath, shower, or sponge bath).
  2. Shampooing.
  3. Oral hygiene and maintenance of dentures.
  4. Foot soaks.
  5. Back massage.
  6. Nails filing.
  7. Shaving.
  8. Provision of incontinent care including changing of diapers.

- LIFE SUPPORT SKILLS
  Assist client with:

  1. Transfers from bed to wheelchair and return; with assistance.
  2. Walking, including cane and walker.
  3. Physical exercises as prescribed by physical therapist.
  4. Arm, leg and hand exercises.
  5. Filling medicine trays. (Relative to dispense, Caregiver to administer)
  6. Accompany client to doctor's appointments. (Family required to arrange transport)
  7. Provide socialization e.g. board games etc.
  8. Maintain care of mobility apparatus, e.g. wheelchair, walker, cane.

- NUTRITION AND HOME MANAGEMENT

  1. Plan and prepare nutritious meals.
  2. Take care of kitchen and utensils after use.
  3. Assist or remind client to take medications.
  4. Check home for safety.
  5. Keep client's room clean.
  6. Assist with client's laundry.
  7. Assist client at mealtimes by feeding when necessary/rinse mouth after eating.
  8. Serve meals at the appropriate temperature.
  9. Ensure portions are adequate.
  10. Encourage client to eat by making meals attractive.
  11. Serve meals on time e.g. (breakfast, snack, lunch, tea, etc.).
  12. Follow doctors, nutritionist, and dietician instructions at all times.

REMEMBER, YOU ARE A SUPPORT TO YOUR CLIENT
SO BE A FRIEND!

MINISTRY OF SOCIAL DEVELOPMENT AND FAMILY SERVICES
Head Office: CL Financial Building, 39-43 St. Vincent Street, Port of Spain.
Tel: 623-2608 • Toll Free 800-1673 • Fax: 623-8496 • **www.social.gov.tt**

HELPING EMPOWERING TRANSFORMING LIVES