STEPS TO OBTAIN A CAREGIVER

1. **COMPLETE THE APPLICATION FOR A CAREGIVER FORM.**
   (Incomplete forms will delay the processing of the application and placement of a Caregiver.)
   Application can be downloaded from the Ministry's website; and emailed or collected from the GAPP Offices.
   Completed forms can be emailed to gapp.info@gov.tt or dropped off at the GAPP Offices.

2. **ATTACH COPIES OF SUPPORTING DOCUMENTS:**
   - Birth Certification of the Client.
   - National Identification of Clients and Next of Kin (Passport, National Identification Card or Driver's Permit).
   - Proof of Address of the Client (utility bill)
   - Up-to-date Medical Record of the Client (signed and stamped).
   - Authorisation Letter for Non-Family Members / Non-Relatives of the Client.

3. **SUBMIT APPLICATION TO GAPP LOCATIONS (see below) or via email at gapp.info@gov.tt :**

WEDNESDAYS	THURSDAYS
Central Regional Office, Eleanore Street, Chaguanas. 623-2608 Ext 6212 - 6213.	East Regional Sub Office, Rio Claro. Lot # 11 Ramrattan's Building Naparima / Mayaro Road, Rio Claro. 644-0849
St Patrick Regional Office, 2nd Floor Siparia Administrative Complex, Corner Allies & S.S. Erin Road, Siparia.	St Patrick Regional Sub Office, St. Patrick West District Youth Office, 6-8 Neverson Street, Mahaica, Point Fortin. 648-6122
North Regional Office, Level 3, Ministry of Sport and Youth Affairs Building #2 Elizabeth Street, St Clair, Port of Spain 612-9367 Ext 8110-8111	
East Regional Office, Community Development Office, Brierley Street, Sangre Grande.	
Victoria Regional Office, Omardeen Building, 59-61 Cipero Street, Gooding Village, San Fernando. 623-2608 Ext 1287-1289.	
North-East Regional Office, Social Welfare Building, 107 Eastern Main Road, Tunapuna. 623-2608 Ext. 1790 and 1731.	

4. **REGIONAL COORDINATOR DOES A NEEDS ASSESSMENT AT THE CLIENT'S HOME BEFORE A CAREGIVER IS ASSIGNED.**
   (This visit can either be virtual or in person.)
   Family members are to assume responsibility in the absence of the Caregiver.

For further information, please contact the GAPP Administrative Office @612-9367 #Ext 8101-8103.

Government of the Republic of Trinidad and Tobago
Ministry of the People, Social Development and Family Services

APPLICATION FOR A CAREGIVER

(Please Complete Form in BLOCK LETTERS)

1. NAME OF APPLICANT: .....
2. ADDRESS(Specific):.....

   .....
3. CONTACT: ..... 4. EMAIL: .....
5. NAME OF CLIENT:.....
6. ADDRESS (Specific):.....

   .....
7. CONTACT: ..... 8. DATE OF BIRTH:.....
9. AGE: ..... 10. SEX: ..... 11. RELIGION: .....
12. MARITAL STATUS: SINGLE ☐ MARRIED WIDOWED DIVORCED OTHER: .....
13. NEXT OF KIN/POWER OF ATTORNEY: .....
14. ADDRESS: .....

    .....
15. CONTACT: ..... 16. RELATIONSHIP: ..... 17. EMAIL: .....
18. NO. OF PERSONS IN THE HOME: ..... 19. NO. OF DEPENDANTS: .....
20. SHORT MEDICAL HISTORY OF CLIENT:
    a. PRESENT MEDICAL CONDITION: .....
.....
    b. IS THE CLIENT MOBILE: YES NO IF "NO" EXPLAIN: .....
.....
    c. OTHER COMMENTS: .....
21. BRIEFLY DESCRIBE SERVICES
    REQUIRED:.....
    .....
22. WOULD YOU ALLOW GAPP'S PERSONNEL TO VISIT CLIENT'S HOME? YES ☐ NO ☐

NEEDS ASSESSMENT WORKSHEETS

This can help the family discuss and decide on the items with which the older person needs or wants assistance.

Please tick (√) which daily activities the elderly person is capable of accomplishing:

(a) Alone ☐

(b) Needs Assistance ☐

(c) Cannot Accomplish ☐

Alone Please consult with your elderly.

ACTIVITIES OF DAILY LIVING (ADL)

Activity	Accomplishes Alone	Needs Some Help	Needs Much Help
Bathing			
Dressing			
Grooming			
Use of the toilet			
Eating nutritious meal			
Getting out of bed			
Getting out of a chair			
Walking			

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

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 limitation - Disabilities or Environmental Barriers. Please 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 and Bowel Control			
Physical Deformity			
Depression			
Chronic sinusitis			
Arthritis			
Hypertension			
Heart Disease			
Diabetes			
Dementia/Alzheimer's			
Parkinson's Disease			
Renal Failure			
Cancer			
Multiple Sclerosis			
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		
☐ Walls in good condition		
☐ Secure and Safe		
☐ Doors secure		
☐ Visible from road		
☐ Passageways clear of wires or materials		
☐ Handrails in the bathroom		
☐ Tiles/Flooring safe		
Stairs		
☐ Free of obstacles and materials		
☐ Well lit		
☐ Handrails on both sides		
☐ In good repair and non-skid		
☐ Safe for walking		

COMMENTS:

ADDITIONAL INFORMATION

- Things older person likes to do during the day?.....
- Is he/she involved in any therapy? (e.g. Plant, pet etc.).....
- What is/are his/ her personal strengths? .....
- Any other problems/issues? .....

SIGNIFICANT OTHERS (INCLUDING FAMILY MEMBERS)

Name	Relationship	Occupation	Capacity to help	Duration of Power of Attorney

FINANCIAL RESOURCES

Monthly Income

☐ 0 - $2,000 ☐ $2,001 - $6,000 ☐ $6,001 - $10,000 ☐ $10,000 and over

Home Owner

Yes ☐ No ☐

Renting

Yes ☐ No ☐

Are you a recipient of any Social Grants?

Yes ☐ No ☐ Pending ☐

If Yes and/or Pending please state: .....

CONFIRMATION OF DURATION OF SERVICE

The duration of the home care services will be an initial six (6) months, followed by a review by the Regional Office. After a successful completed review, services may continue for up to six months. This will take Home Care Services for the maximum of 12 months.

Please Initial to confirm your understanding of the duration of Caregiver's Service: .....
Initial

CAREGIVER PLACEMENT SERVICES

I …… hereby certify that:

1. The above given information is true and correct. I understand that otherwise my application will be made void.
2. I will comply with GAPP's Policies and Code of Conduct.
3. Your application may be deferred if the home does not meet the required standard.
4. I will comply with the Minimum Wages Act and other statutory requirements, if necessary.

Signature of Applicant: ..... Date: .....

For Official Use

Date Application Received: …… Receiving Officer: ……..

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

Community Placement Services ☐ Private Placement Services ☐

Applicant's Consecutive No.: ……

Project Coordinator /f/: …… Official Stamp:

RESPONSIBILITY OF A CAREGIVER TO CLIENT

Listed below are the duties/responsibilities of caregivers where applicable.

- **PERSONAL HYGIENE (Daily Living Activities)**

  Assists 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**

  Assists client with:

  1. Transfers from bed to wheelchair and return; with assistance.
  2. Walking (this also include cane and/or 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**

  Assists client with:

  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 CLEINT, SO BE A FRIEND.