Program Registration - Caregiver

Referring Agency:

Referring Staff's Name: Referring Staff's Title	Phone: Email:

Contact Date / /	Release of Information signed on:	**ID Number / Initial**

Basic Demographics

Last Name:	First Name:	Middle Initial:
Lives in Rural Area [ ] Yes [ ] No	Gender: [ ] Female [ ] Male [ ] Unspecified	Date of Birth:

Address:	Address #2:

City:	State:	Zip Code:	County:

Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( )

Social History

Race (Check one): [ ] African [ ] African American [ ] American Indian [ ] Asian/Pacific Islander [ ] White [ ] Other (specify) _____ [ ] Missing/not specified [ ] Hispanic/Latino	Preferred Language: [ ] English [ ] Hmong [ ] Somali [ ] Oromo [ ] Spanish [ ] Other, (specify: _____) [ ] Missing/not specified

Care Receiver

What is the care receiver's name?

(Last)_____ (First)_____ (Middle Initial)_____

What is the care receiver's date of birth? _____/_____/_____

What is your relationship to the care receiver? (Circle one) Husband Wife son/son-in-law

daughter-in-law Other relative non-relative

What is the approximate monthly income? $_____

Use of Information

I understand that the information I am providing on this form is for registration purposes. The information will be used by the U.S. Health and Human Services Administration for Community Living (ACL), the Minnesota Board on Aging (MBA) and the local Area Agency on Aging to create statistical reports. ACL, MBA or its assignees may use this information to conduct a study and/or survey of this service. In addition, information provided here, may be used by other service providers to help identify other services from which I may benefit. This information will not be released to anyone other than the above mentioned parties in a way that will identify me as an individual unless I sign a separate consent for that purpose.

Signature: _____ Today's Date:_____