



The Council of the Isles of Scilly Adult Services

Carer's Self Assessment Form

We need to check

Are you are carer? yes no

Are you over 18? yes no
(If you are under 18 please contact Children's Services on 01720 424040)

Does the person you care for live within the Isles of Scilly?

yes no

Is the person you care for over 18?

yes no
(If the person you care for is under 18 please contact Children's Services on 01720 424040)

About you

Title _____

First name _____

Family name _____

Your address _____

Your postcode _____

Your email address _____

Contact phone number _____

Date of birth (dd/mm/yyyy) _____

Gender: female male

Doctors Name _____

Have you made your doctor aware that you are a carer?

yes no

Your commitments

Dependant children and/or family commitments yes no

Please give details

Do you have any other commitments such as:

Paid Employment yes no

Study or training yes no

Voluntary work yes no

Attend regular leisure activities/groups? yes no

Please give details of these commitments:

Does your caring role prevent you from doing any of these commitments?

yes no

About you and your family's health and well being

Do you have any health needs/disabilities/sensory needs?

yes no

Please give details of your health needs/disabilities/sensory needs:

Have you recently had any health concerns or issues?

yes no

Do you have any planned hospital admissions?

yes no

Do you have any cultural, faith and/or religious needs?

yes no

Please tell us below how your caring role affects you physically and emotionally:

Has caring affected you financially?

Do you receive a carer's allowance?

yes

no

About the person you care for

Title _____

First name _____

Family name _____

Date of birth (dd/mm/yy) _____

Gender: female male

Do you live with this person? yes no *(if no please give details of their address below)*

Address _____

Their postcode _____

Their contact telephone number _____

What relationship to you is this person? _____

Doctors Name _____

Learning Difficulty yes no

Physical Impairment yes no

Sensory Impairment yes no

Mental health yes no

Dementia-type illness yes no

Old & Frail yes no

Other problem yes no

Specification of Other Problem _____

About the Care You Provide

How long have you been caring for this person?

- | | |
|--|--|
| <input type="checkbox"/> less than a month | <input type="checkbox"/> 1-2 years |
| <input type="checkbox"/> 1-3 months | <input type="checkbox"/> 2-5 years |
| <input type="checkbox"/> 3-6 months | <input type="checkbox"/> more than 5 years |
| <input type="checkbox"/> 6-12 months | |

Time you spend caring

- | | | |
|--|---------------------------------------|--------------------------------|
| <input type="checkbox"/> Only in emergencies | <input type="checkbox"/> Occasionally | |
| <input type="checkbox"/> Several times a month | <input type="checkbox"/> Weekly | <input type="checkbox"/> Daily |

Hours a month

- 10 hours or less
 more than 10 hours

Hours a week

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> 1-5 hours | <input type="checkbox"/> 16 – 21 hours |
| <input type="checkbox"/> 6-10 hours | <input type="checkbox"/> more than 21 hours |
| <input type="checkbox"/> 11-15 hours | |

Hours a day

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> 1-5 hours | <input type="checkbox"/> 13-18 hours |
| <input type="checkbox"/> 6-12hours | <input type="checkbox"/> 19-24 hours |

Does the person you care for receive services from anyone else?

- yes no

Details of care:

How do you feel?

- I feel able to continue with the level of care I am providing
- I need more support to enable me to carry on
- I can only carry on if I reduce the amount of caring I am providing
- I feel I cannot carry on caring at all

Tell us more about how you feel about the care you provide:

Tell us about the assistance you provide

Please tell us about the assistance you provide for the person you care for:

(please tick all the help that you give and indicate how often and whether it is difficult to give this help)

Tasks	How often?				How difficult?		
	Daily	Weekly	Monthly	No not needed	Not difficult	Sometimes difficult	Always difficult
Help with taking medication (obtaining & taking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving emotional support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing their money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other financial support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making sure the persons is safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with a crisis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with difficult behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving/arranging transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dealing with aggression, violence or verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help with personal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help with practical tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home minor health tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the space below please identify other caring tasks that you carry out:

What would help support you in your caring role?

- | | | |
|----------------------|------------------------------|-----------------------------|
| Advice & Information | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Aids for the home | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Carer's breaks | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Other help is needed | <input type="checkbox"/> yes | <input type="checkbox"/> no |

If yes, then please tell us about the support you need:

Changes to the home environment

For example provision of the aids and adaptations from the list below may support you in your caring role, for instance by assisting you to promote the independence of the person you care for.

Rails

- stair rail
- toilet grab rail
- grab rail(s) for internal steps between rooms
- grab rail to wall of front or back door

Personal care equipment

- commode
- folding bottom wiper
- long handled sponge or toe wiper
- stocking aid
- long shoe horn

Food & drink aids

- insulated mug
- caring cup (two handled mug)
- plate guard

Other Items of use *(please specify below)*

Does this person rent or own their home?

- They are a home owner
- Tenant renting from the Council
- Tenant renting from a Housing Association
- Not a home owner or tenant

Taking a break

Someone to stay with the person you care for to allow you to have a break or a holiday. This is to cover a period of time you would normally be there. For example a couple of hours a week; or a week's break on a regular basis; or an occasional break.

What kind of break would help you?

Please give details

How could someone help you with caring tasks?

Advice & Information

- about carer's support networks
- benefit advice
- advice on moving & handling
- advice about managing difficult behaviour
- cleaning services
- accessing community services
- accessing health services (e.g. getting to appointments)

Other advice

Equal opportunities monitoring

The Council of the Isles of Scilly is committed to promoting equality of opportunity for everyone. Our aim is to provide services fairly and without discrimination. Please provide the following information to help us monitor which groups in our community are using our services.

How would you describe your race or ethnic origin?

- White – British
- White – Irish
- Any other White background
- Mixed – White & Black Caribbean
- Mixed – White & Black African
- Mixed – White & Asian
- Any other mixed background
- Asian or Asian British
- Black or Black British
- Chinese
- Any other ethnic background (specify below)
- I do not want to give this information

If other ethnic background, please describe:

Do you consider yourself a disabled person?

- yes
- no

Religion & Belief

- Christian
- Muslim
- Hindu
- Sikh
- Jewish
- other
- none

You have finished the self assessment form

Did you have assistance to complete this self assessment?

yes no

What did you think about this form?

Please email this form to jpersich@scilly.gov.uk

Or send to:

Adult Services
The Town Hall
St Mary's
Isles of Scilly
TR21 0LW

You will receive a response within two working days from receipt of your application. If it seems that your needs are complex and we think you would benefit from a professional face to face assessment we will tell you this. If we agree that you qualify for support, you will be offered services matching your assessed needs.

If you have any questions, please contact the Adult Services Office on:
Telephone 01720 422148
Email jpersich@scilly.gov.uk