COUNCIL ON AGING
OF CENTRAL OREGON

Caring Connections Client Enrollment

Date:	**Completed by:**

1. Name:	**2. DOB:**
3. Phone: ☐ Landline ☐ Cell phone	**4. Address:** ☐ Rural
5. Email?	**6. Virtual calls/Texts?**

Goal of Caring Connections:

This program is designed to help ease feelings of social isolation and/or loneliness. We know that social connections can lead to better health and improved well-being and we hope that this program can offer you support that will make you feel more connected.

UCLA 3-Item Loneliness Scale:

- You will be asked these questions now and then again annually
- Response is optional but meaningful
- We hope to see improvement over time

7a. How often do you feel you lack companionship?

Hardly ever / Some of the time / Often

7b. How often do you feel left out?

Hardly ever / Some of the time / Often

7c. How often do you feel isolated from others?

Hardly ever / Some of the time / Often

8. What factors contribute to your feelings of social isolation and/or loneliness?

Lubben Social Network Scale (LSNS-6)

- "Consider all the people who you are related to by birth, marriage, adoption, etc."
- "Consider all your friends, including people who live in your neighborhood."

9a. How many family members do you see or hear from at least once a month?

0	1	2	3-4	5-8	9+

9b. How many family members can you talk to about private matters?

0	1	2	3-4	5-8	9+

9c. How many family members do you feel that you could call on for help?

0	1	2	3-4	5-8	9+

9d. How many friends do you see or hear from at least once a month?

0	1	2	3-4	5-8	9+

9e. How many friends can you talk to about private matters?

0	1	2	3-4	5-8	9+

9f. How many friends do you feel that you could call on for help?

0	1	2	3-4	5-8	9+

12a. Living place: ☐ My home ☐ Someone else's home ☐ Assisted living facility ☐ Independent senior living ☐ Nursing home ☐ Group home	**12b. Other inhabitants:** ☐ Alone ☐ With family ☐ With spouse/partner ☐ With caregiver ☐ With roommates
13a. Emergency contact:	**13b. EC phone:**
13c. EC relationship to participant:	**14. Explain emergency protocol. Consent to welfare check.** Y / N
15. Caregiver: ☐ Paid ☐ Unpaid	**16. Existing care level:** ☐ Full-time ☐ Part-time ☐ Fully independent
175. Referral source:	**18. MOW participant:** Y / N / Waitlist
19. Received visit from CoA case manager: Y / N	**20. Approved for in-home visits:** Y / N
21. Diagnosed with dementia or Alzheimer's: Y / N	**22. Displayed cognitive/memory issues:** Y / N

23. "Did you serve in the military?" Y / N	**24. Are you connected with any counseling resources? In the past?** Y / N
25a. Limitations: ☐ Hearing impairment ☐ Vision impairment ☐ Difficulty walking up stairs ☐ Difficulty getting in/out of car ☐ Difficulty communicating/being understood	Difficulty with mood ☐ intense feelings ☐ controlling behavior ☐ delusions/hallucinations Difficulty ☐ concentrating ☐ remembering things ☐ making decisions
25b. Mobility device? Recent falls?	**25c. "Do you identify as having a disability?"** Y / N
26. Smoking in the home? Y / N	**27. Pets?** Y / N
28. Visible hoarding? Cleanliness? Y / N	**29. "How would you describe your gender?"**
30a. "How would you describe your racial identity?" ☐ American Indian or Alaskan Native ☐ Asian / Pacific Islander ☐ Black or African American ☐ Hispanic / Latino ☐ White / Caucasian ☐ Multiple ethnicity / Other ☐ Prefer not to say	**30b. Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Rather not say
31a. Primary Language:	**31b. Secondary Language?**

34. Insurance:	**35. Additional resources shared:**
☐ Medicare ☐ Medicaid ☐ OHP/PacificSource ☐ Private ☐ VA	

36. Biographical notes:
37. Preferences on volunteer match or activities of interest:
38. Is there anything else we should know about you?
38. What are you hoping to get out of the Caring Connections program?
39. What are you hoping to contribute to your Caring Connections experience? (or “What is something about yourself that you like sharing with others?”)