**April 2015**

**Adults and Communities**

**Carer’s Assessment**

This form is for you to tell us about yourself. It asks questions about your health and safety, what information or advice you may need to support you as a carer and what outcomes you would like to achieve outside of your caring role.

Please fill in as much information as possible. You can complete the form with help from a friend, a member of your family or a health or social care professional.

***If you would like to expand on any of the questions, please use a blank page.***

|  |
| --- |
| 1. **Your personal details and contact information**
 |
| Title |       |
| Name  |  |
| Date of birth |       |
| Address |  |
| Gender |       |
| Ethnicity  |  |
| Religion  |  |
| Phone number |       |
| Email address  |  |
| NHS Number |  |
| GP name and address |  |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].pngDoes your GP know you are a carer?  | Yes [ ]  No [ ]  |
| SWIFT Number *(to be completed by a professional)* |       |
| **Language and communication**  |
| Preferred language  |  |
| Do you need an interpreter?  | Yes [ ]  No [ ]  |
| If yes, give details of the arrangements*(to be completed by a professional)*  |  |
| Do you have any special communication needs? |  |
| If yes, give details of the arrangements*(to be completed by professional)*  |  |
| Preferred method of communication |  |
| 1. **Capacity and consent** *(to be completed by a professional)*
 |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].pngDoes the person have substantial difficulty taking part in this social care process?  | Yes [ ]  No [ ]  |
| If yes, give details of the person’s ability to understand, retain and weigh up information. |
|  |
| Describe the steps taken to enable the person to be fully involved in the process. |
|  |
| Has a mental capacity assessment been completed? If yes, please provide details below: | Yes [ ]  No [ ]  |
|  |
| Date |  | Details |  |
| Is an IMCA required? | Yes [ ]  No [ ]  |
| Is there an appointee because of mental capacity or legal requirement? | Yes [ ]  No [ ]  |
| If yes, please provide details of named person: |
| Name |  | Telephone |  |
| Relationship |  | Email |  |
| Is there a registered lasting / enduring Power of Attorney? | Yes [ ]  No [ ]  |
| If yes, record type of registered lasting / enduring Power of Attorney | *Please select…* |
| If yes, please provide details of named person: |  |
| Name |  | Telephone |  |
| Relationship |  | Email |  |
| Does the person have a Deputy under the Court of Protection? | Yes [ ]  No [ ]  |
| If yes, please provide details of named person: |
| Name |  | Telephone |  |
| Relationship |  | Email |  |
|  |
| **Your consent**  |
| I (or my representative) give consent for information from this assessment to be shared as needed with other agencies involved in my care | Yes [ ]  No [ ]  Yes with limitations [ ]   |
| Date of consent given / refused |  |
| If you ticked ‘yes with limitations’ please provide details of requested limitations |  |
| 1. **Details of the person/people that you care for**
 |
| Name |       |
| Date of birth |       |
| Address |  |
| Gender |       |
| Ethnicity  |       |
| Religion |  |
| Phone number |       |
| NHS number |  |
| GP name and contact details |       |
| 1. **About your caring role**
 |
| What is your relationship to the person you care for? |  |
| How long have you been caring for them? |  |
| Do you feel that you have enough information about the condition or diagnosis the person you are providing care for, and the treatment they are receiving?  | Yes [ ]  No [ ]  |
| If no, please explain what information you feel you may benefit from? |
| Please tell us if you have any concerns about your safety in your caring role or the person you are caring for? |
|  |
| Are you able or willing to continue caring in your caring role? | Yes [ ]  No [ ]  With support [ ]  |
| **Your caring responsibilities** Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].pngWhat help or support do you provide to the person you care for? |
|  |
| What help do you receive? |  |
| Do you require any extra help? | Yes [ ]  No [ ]  |
| What do you need help with? |  |
| Any additional comments |  |
| **Your wellbeing** Please tell us about how your caring role affects your general health and wellbeing. For example, you may want to tell us if you have any concerns about your health, if you have any diagnosis / registered disability, if your caring role interferes with your sleep, affects your mood or how you feel, or causes you any physical pain or strain. |
|  |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].png**Your family and personal relationships**Do you feel that your caring role is impacting on your ability to maintain family and other relationships? | Yes [ ]  No [ ]  |
| What help do you receive? |  |
| What do you need help with? |  |
| Any additional comments |  |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].png**Home environment** Do you feel your caring role is impacting your ability to maintain your home? | Yes [ ]  No [ ]  |
| What help do you receive? |  |
| What do you need help with? |  |
| Any additional comments |  |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].png**Paid work, training or volunteering** Are you currently working, training, in education or volunteering? Please provide details: |
|  |
| What help do you receive? |  |
| What do you need help with? |  |
| Any additional comments |  |
| Description: C:\Users\p10248012\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\YKHT796D\qOXqp[1].png**Recreational and community activities** Do you feel your caring role is impacting your ability to engage in community and recreational activities? If yes please provide details: | Yes [ ]  No [ ]  |
|  |
| What help do you receive? |  |
| What do you need help with? |  |
| Any additional comments |  |
|  |
| 1. **Emergency plans**
 |
| Do you have plans in place if you were ill or unable to carrying on supporting the person you care for?  | Yes [ ]  No [ ]  |
| ***If yes, please provide a copy of your plan.*** |  |
| If you do not have any plans in place, you can complete a [**Carers Emergency Plan**](https://www.barnet.gov.uk/citizen-home/adult-social-care/carers-in-barnet/Emergency-plans-for-carers.html)**,** this can be requested from your health or social worker or downloaded from the Council’s website: [www.barnet.gov.uk/carers](http://www.barnet.gov.uk/carers)  |
|  |
| 1. **Summary of identified needs** *(to be completed by a practitioner)*
 |
| Is the caring role having a significant impact on carer’s life and wellbeing? | Yes [ ]  No [ ]  |
| Is the carers physical or mental health deteriorating or at risk of doing so as a result of their caring role? | Yes [ ]  No [ ]  |
| ***Needs in relation to outcomes:*** |
| Providing care to other persons for whom the carer provides care | Eligible [ ]  Non-Eligible [ ]   |
| Maintaining a habitable home environment | Eligible [ ]  Non-Eligible [ ]   |
| Managing and maintaining nutrition needs | Eligible [ ]  Non-Eligible [ ]   |
| Developing and maintaining family and other personal relationships | Eligible [ ]  Non-Eligible [ ]   |
| Engaging in work, training and volunteering  | Eligible [ ]  Non-Eligible [ ]   |
| Making use of necessary facilities or services in the local community | Eligible [ ]  Non-Eligible [ ]   |
| Engaging in recreational activities | Eligible [ ]  Non-Eligible [ ]   |
| 1. **Summary of non-eligible needs** *(to be completed by a practitioner)*
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|  |
|  |
| 1. **Eligibility decision** *(to be completed by a practitioner)*
 |
| Does the carer meet the eligibility criteria for council support? If no, please provide details below: | Yes [ ]  No [ ]  |
|  |
|  |
|  |
| 1. **Estimated personal budget** *(to be completed by a practitioner)*
 |
| *Access the ready reckoner for carers* |
|  |
| 1. **Information and advice** *(to be completed by a practitioner)*
 |
| Has information and advice concerning financial assessment and council service charges been provided? | Yes [ ]  No [ ]  |
| Community Activities | [ ]  | Direct Payments | [ ]  | Help at Home | [ ]  |
| Leisure | [ ]  | Financial Information | [ ]  | Housing | [ ]  |
| Transport | [ ]  | Equipment at Home | [ ]  | Community Safety | [ ]  |
| Employment/ Learning/ Volunteering | [ ]  | Adaptations | [ ]  | Advocacy | [ ]  |
| Safeguarding | [ ]  | Telecare | [ ]  | Health | [ ]  |
| Carers | [ ]  | Prescriptions | [ ]  | Other | [ ]  |
| Further information provided:  |
| Does the person need support to manage their income or access benefits? If yes, please provide details below: | Yes [ ]  No [ ]  |
|  |
| Would the person benefit from some independent financial advice and information? | Yes [ ]  No [ ]  |
| BCAB – Info and Advice, Advocacy  | [ ]  | Barnet Eclipse – MH and Wellbeing | [ ]  | Healthwatch Barnet | [ ]  |
| BCAB – Community advice | [ ]  | Barnet Mencap | [ ]  | My Care My Home | [ ]  |
| BCIL – support planning | [ ]  | Dimensions – Autism and LD | [ ]  | Barnet Outreach | [ ]  |
| Age UK Barnet | [ ]  | Barnet Carers Trust | [ ]  | Other | [ ]  |
| If other please specify: |  |
|  |
| 1. **Declaration**
 |
| Signature of person assessed  |  |
| If you have had help completing this form, the person who has filled it in must sign and date the form below stating their relationship to the carer, or their job title. Please provide your telephone number and give the reason why the carer was unable to complete the form.  |
| Signature of nominee or representative |  |
| Relationship to carer |  | Phone |  |
| Is the carer aware of this referral | Yes [ ]  No [ ]  | Email |  |
| Date of assessment |  |

**Please return your completed form to the health or social care worker who gave it to you, or send it to:**

* **For adults with a physical or sensory impairment, or people over 65:**
Social Care Direct, POST ROOM,
Building 4, North London Business Park, Oakleigh Road South N11 1NP
* **Email:- socialcaredirect@barnet.gov.uk**
* **For adults with a learning disabilities**:
Learning Disabilities, POST ROOM, Adults and Communities, Building 4, North London Business Park, Oakleigh Road South N11 1NP
* **For people with a mental health problem:**Primary Mental Health Team,
2nd Floor, Dennis Scott Unit, Edgware Community Hospital, Burnt Oak Broadway, Edgware HA8 0AD

**Thank you for completing this form**

**Privacy Statement:**

Barnet Council has a duty to protect the public funds it administers and may use the information you have provided for the prevention and detection of crime.  We may also share information with other council departments or external organisations in order to undertake our functions as a local authority. We will always comply with the requirements of the Data Protection Act 1998 and never give information about you to anyone else, or use information for another purpose unless the law allows us. If you want to know more about how your information is used visit [www.barnet.gov.uk/privacy](http://www.barnet.gov.uk/privacy).