



**California Indian Manpower Consortium, Inc.
Elders Program**



Elder Caregiver Training Application Form

Date: December 9, 2024 – December 12, 2024 **Time:** 8:00 AM to 5:00 PM

Location: Pala Casino Resort Spa
11154 CA-76
Pala, CA 92059

Participant Information: Please TYPE or PRINT CLEARLY

Name:	
Home Address:	
Mailing Address (if different from Home Address):	
Caregiving Services for which Tribe:	<input type="checkbox"/> Berry Creek <input type="checkbox"/> Big Sandy <input type="checkbox"/> Chico/Mechoopda <input type="checkbox"/> Cold Springs <input type="checkbox"/> Coyote Valley <input type="checkbox"/> Enterprise <input type="checkbox"/> Fort Bidwell <input type="checkbox"/> La Jolla <input type="checkbox"/> Mooretown <input type="checkbox"/> North Fork <input type="checkbox"/> Pauma <input type="checkbox"/> Robinson <input type="checkbox"/> San Pasqual <input type="checkbox"/> Santa Ysabel <input type="checkbox"/> Scotts Valley <input type="checkbox"/> Sherwood <input type="checkbox"/> Susanville <input type="checkbox"/> Upper Lake
Telephone:	
Fax:	
Email:	
Date of Birth:	
Dietary Restrictions:	
Special Needs:	

Emergency Contact Information: Please TYPE or PRINT CLEARLY

Contact Name:	
Contact Phone Number:	
Contact Secondary Phone Number:	

Caregiver Questionnaire

1.	Why do you want to attend the caregiver training?		
2.	Do you currently have an Adult CPR/Standard First Aid Card? If yes, please attach a copy of your Adult CPR/Standard First Aid Card with the expiration date.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.	Do you currently provide caregiving services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4a.	Are you currently employed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4b.	If yes, please check one: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time		
5a.	Are you currently providing caregiving for a family member?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5b.	If no, whom do you provide caregiving services for (check one): <input type="checkbox"/> Neighbor <input type="checkbox"/> Friend <input type="checkbox"/> Other		
If other, please explain:			
5c.	If yes, whom do you provide caregiving services for (check one): <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		
If other, please explain:			
6.	Please indicate any resources you have accessed for caregiving:		
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
County Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No
State Services		<input type="checkbox"/> Yes	<input type="checkbox"/> No
IHS		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Area Agency on Aging		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Health Insurance Company		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Internet		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do you currently travel to provide services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7a.	If yes, how far do you travel?		