



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



Elder Caregiver Health and Wellness Conference Registration Form

Date: September 26 & 27, 2017 **Time:** 8:00 am to 5:00 pm

Location: Gold Country Hotel
4020 Olive Hwy
Oroville, CA 95966

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"/> Big Sandy <input type="checkbox"/> Berry Creek <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"/> Mooretown <input type="checkbox"/> Pauma <input type="checkbox"/> Robinson <input type="checkbox"/> Santa Ysabel <input type="checkbox"/> San Pasqual <input type="checkbox"/> Susanville <input type="checkbox"/> Upper Lake <input type="checkbox"/> Sherwood Valley <input type="checkbox"/> North Fork, Madera, Fresno, Mariposa <input type="checkbox"/> Scotts Valley, Sonoma, Contra Costa, Lake
Telephone:	
Fax:	
Email:	
Date of Birth:	
Dietary Restrictions:	
Special Needs:	

Emergency Contact Information: Please TYPE or PRINT CLEARLY

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

Caregiver Health and Wellness Questionnaire

1.	Why do you want to attend the caregiver training?		
2.	Do you currently provide caregiving services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3a.	Are you currently employed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3b.	If yes, please check one: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time		
4a.	Are you currently providing caregiving for a family member?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4b.	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:			
4c.	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:			

5.	Please indicate any resources you have accessed for caregiving:		
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	
6.	Do you currently travel to provide services?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6a.	If yes, how far do you travel?		