



Dear [Click or tap here to enter text.](#),

I wanted to personally Thank You for referring caregivers to the Lifespan Respite Voucher Program. Without referrals, the program would not be the success that it is. I would like to share a few tidbits of information with you that I hope you will find informative and encouraging.

- From the beginning of the voucher program in August 2015 there have been 434 different caregivers that have received a respite voucher.
- There are currently 234 caregivers with open vouchers that may be used to get a break!
- We have a very active coalition that helps with planning and promoting activities of the Lifespan Respite Program.
- We have an email network that keeps interested Montanans up to date on anything related to Lifespan Respite.

(If you are interested in being on the coalition or on the email list, please let me know and I will get you connected.)

- There are several Aging Horizons shows that feature Lifespan Respite and are a great source of information about the program. The address to watch any of these shows is: [www.youtube.com/montanaDPHHS](http://www.youtube.com/montanaDPHHS) and search for Lifespan Respite.
- Within the next year we will be recruiting and offering training to respite providers that are interested in having their names on a database that caregivers will be able to access when looking for a respite provider. More information will be sent through our email network.

Below are some things that I have noticed that may not be clear when referring a caregiver to the Lifespan Respite Voucher Program:

- A Caregiver Strain Index is part of the application process and must be completed and returned with the application. It can be found on the [respite.mt.gov](http://respite.mt.gov) website. I have included it in this packet.

- An application is not complete unless **ALL** of the items listed on page 5 of the application are included. Missing any of these items will delay processing and approval of the application. The list includes:
  - ✓ Proof of Primary Caregiver's Address (**only** if living separate from the care recipient)
  - ✓ Proof of Care Recipient's Age (birth certificate or ID)
  - ✓ Income Verification (Tax return, bank statement, check stubs, Social Security letter, etc.)
  - ✓ Medical Expense Verification (if any. If the care recipient is under 18 or the spouse of the caregiver, the entire family's medical expenses can be used.)
  - ✓ Modified Caregiver Strain Index (mentioned above)
- Families with more than one child do not get separate vouchers for each child. One voucher can be used for all of the children.
- We cannot pay the respite provider directly.
- We cannot pay the primary caregiver for taking care of their loved one.

I have included the FAQ sheet about the Lifespan Respite Voucher Program along with our brochures, my business card and since we have changed our application over the years, I have included the current version, which can also be found on the website [www.respite.mt.gov](http://www.respite.mt.gov).

I am also including the application, FAQ sheet and survey for our Dementia/Alzheimer's Voucher Program. This program is for care recipients that have some form of memory loss. It is paid from a separate grant, funded by the Administration for Community Living. The application is simpler and there is a different survey that accompanies the application. With this program, caregivers may request a one-time \$150 to purchase items that help make respite possible such as ID bracelets, door alarms, simple cameras or specific transportation for example. Using this funding source for those with memory loss frees up money in the Lifespan Respite budget for more recipients in other populations. The FAQ sheet provides the criteria for use of the Dementia/Alzheimer's voucher program.

Thank you again for referring caregivers to our respite voucher programs and please feel free to call me with questions about either program, I am happy to help!

Sincerely,

Vicki Clear  
Montana Lifespan Respite Voucher Coordinator

## Montana Lifespan Respite (LSR) Coalition

The Montana LSR Coalition is a group of individuals from agencies, state departments and non-profits, caregivers, and others interested in improving the quality of life of family caregivers and those that need support.

### Mission Statement

To establish a statewide, coordinated system of easily accessible, quality, and affordable respite care services for Montana's family caregivers of individuals regardless of special needs.



### Vision Statement

To provide all family caregivers access to a quality community-based respite care service that is affordable and flexible to meet their needs.

## Lifespan Respite:

- ✓ For all ages.
- ✓ For families and individuals who identify a critical need for relief, regardless of age, income, race, ethnicity, special need or situation.
- ✓ For maintaining caregiver health, decreasing family stress, reducing risk of abuse and neglect, and out-of-home placement.

### For more information contact:

DEAP  
2200 Box Elder, Suite 151  
Miles City, MT 59301  
Phone: 406-234-6034  
1-800-224-6034  
or  
Aging & Disability Resource Centers  
for respite assistance  
1-800-551-3191  
Mon – Fri 8AM to 5PM



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## Montana Lifespan Respite Voucher Program

**It's OK to need it.  
It's OK to want it.  
It's OK to get it!**



## What is Respite?

- ➔ Respite is a temporary break for family and individual caregivers.
- ➔ Respite may include in-home care, companionship or outings.

## How does the Montana Lifespan Respite Voucher Program work?

- ➔ The respite voucher program is an opportunity for family and individual caregivers with limited resources to obtain assistance and get a break from their caregiving responsibilities.
- ➔ Funding is available and may require a co-pay, based on a sliding fee scale according to income.

## How do I apply?

- ➔ Complete an application and submit with all the required information. Applications can be filled out online at [www.respite.mt.gov](http://www.respite.mt.gov) or call 1-800-551-3191 to have an application mailed to you.

## What happens next?

- ➔ You will receive a phone call within five working days to let you know if you have been approved for funding and the voucher process will be explained.
- ➔ If approved, you will receive a respite packet in the mail and will have 90 days to use the approved respite amount.

## Who provides the respite?

- ➔ You may go through an agency that employs respite providers, hire a private respite provider or you may use a combination of both. The respite provider cannot live in the same household as the care recipient and must be at least 18 years of age.

## How do I find an agency that employs respite providers where I live?

- ➔ Review the searchable database on the respite website, [www.respite.mt.gov](http://www.respite.mt.gov) where you can search for agencies that employ respite providers as well as other resources available in your area.

## What if I need help with the paperwork or finding resources?

- ➔ You may call 1-800-224-6034 or  
(406) 234 – 6034  
Mon – Fri 8AM to 5PM



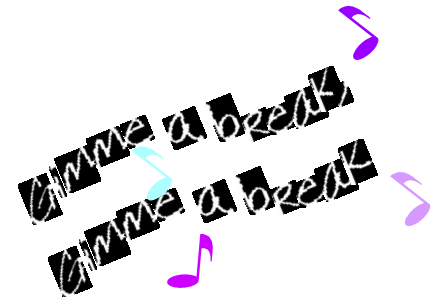
**It's OK to need it, It's OK to want it, and it's OK to get it!**

▶ *The Coalition's Definition of Respite:*

*"planned or emergency care provided to an individual with need for support and supervision in order to provide temporary relief to the primary caregiver of that individual"*

Montana Lifespan Respite Voucher Program  
*Answers to Frequently Asked Questions*

- Available in all of Montana
- Available to all ages (lifespan)
- There must be a primary caregiver to apply for the voucher
- Reimburses the caregiver
- There is a cost share based on net income after ongoing medical expenses are deducted
- Medical Expenses, with proof of expense, include:
  - Doctor/Clinic bills
  - Dentist bills/ other dental items
  - Vision or hearing specialist bills/devices
  - Insurance premiums, including Medicare supplements
  - Insurance deductibles
  - Prescription medicines
  - Health care facility expenses
- Applications are for a maximum of \$400 initially
- \$200 additional may be requested within the year (\$600 max per calendar year)
- Caregiver may choose a respite provider through an agency or hire someone privately
  - Respite provider must be at least 18 years of age
  - Respite provider cannot live in the same household as the person being cared for
- Respite Vouchers may be used to help pay for respite care in a facility
- A satisfaction survey must be completed and returned with the reimbursement form to get reimbursed.



2200 Box Elder, Suite 151  
 Miles City, MT 59301  
 Phone: 406-234-6034  
 1-800-224-6034  
 Mon – Fri 8AM – 5 PM



Aging & Disability Resource Centers  
 for respite assistance  
 1-800-551-3191  
 Mon – Fri 8AM to 5PM



## Dementia/Alzheimer's Grant Voucher Program At a Glance

- Available to individuals living in Montana
- Care recipient must have some form of memory loss requiring a caregiver
- There must be a primary caregiver to apply for the voucher
- Voucher program is administered by DEAP in Miles City
- Individuals are only eligible for one Voucher program at a time through DEAP
- Reimbursements are made to the primary caregiver
- Caregiver may choose a respite provider through an agency or hire someone privately
  - Respite provider must be at least 18 years of age
  - Respite provider cannot live in the same household as the person being cared for
- Funding available for assistive devices (ID bracelets, door alarms, etc.)
- Applications are normally for \$600 initially
- \$200 additional may be requested within the calendar year



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for respite assistance  
1-800-551-3191  
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## Pre-Respite Survey Alzheimer's Grant

Care Recipient Name \_\_\_\_\_

Caregiver Name \_\_\_\_\_

**Choose the number that best represents how often the statement describes your feelings.**

0 - Never   1 - Rarely   2 - Sometimes   3 - Quite Frequently   4 - Nearly Always

(He/She refers to the person you are responsible for taking care of)

He/she needs my help to perform many daily tasks  
0            1            2            3            4

He/she is dependent on me  
0            1            2            3            4

I have to watch him/her constantly  
0            1            2            3            4

I have to help him/her with many basic functions  
0            1            2            3            4

I don't have a minute's break from his/her chores  
0            1            2            3            4

I feel that I am missing out on life  
0            1            2            3            4

I wish I could escape from this situation  
0            1            2            3            4

My social life has suffered  
0            1            2            3            4

I feel emotionally drained due to caring for him/her  
0            1            2            3            4

I expected that things would be different at this point in my life  
0            1            2            3            4

I'm not getting enough sleep

0            1            2            3            4

**Choose the number that best represents how often the statement describes your feelings.**

0 - Never    1 - Rarely    2 - Sometimes    3 - Quite Frequently    4 - Nearly Always

(He/She refers to the person you are responsible for taking care of)

Caregiving has made me physically sick

0            1            2            3            4

I'm physically tired

0            1            2            3            4

I feel embarrassed over his/her behavior

0            1            2            3            4

I feel ashamed of him/her

0    0            1            2            3            4

I resent him/her

0            1            2            3            4

I feel uncomfortable when I have friends over

0            1            2            3            4

I feel angry about my interactions with him/her

0            1            2            3            4

I don't get along with other family members as well as I used to

0            1            2            3            4

My caregiving efforts aren't appreciated by others in my family

0            1            2            3            4

I've had problems with relationships

0            1            2            3            4

I don't get along as well as I used to with others

0            1            2            3            4

I feel resentful of other relatives who could but do not help

0            1            2            3            4

Other comments \_\_\_\_\_



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**Pre-Respite Survey**  
**(This form is required by the grant)**

Care Recipient Name \_\_\_\_\_

Caregiver Name \_\_\_\_\_

**Choose the number that best represents how often the statement describes your feelings.**

0 - Never   1 - Rarely   2 - Sometimes   3 - Quite Frequently   4 - Nearly Always

(He/She refers to the person you are responsible for taking care of)

He/she needs my help to perform many daily tasks	0	1	2	3	4
He/she is dependent on me	0	1	2	3	4
I have to watch him/her constantly	0	1	2	3	4
I have to help him/her with many basic functions	0	1	2	3	4
I don't have a minute's break from his/her chores	0	1	2	3	4
I feel that I am missing out on life	0	1	2	3	4
I wish I could escape from this situation	0	1	2	3	4
My social life has suffered	0	1	2	3	4
I feel emotionally drained due to caring for him/her	0	1	2	3	4
I expected that things would be different at this point in my life	0	1	2	3	4
I'm not getting enough sleep	0	1	2	3	4
Caregiving has made me physically sick	0	1	2	3	4
I'm physically tired	0	1	2	3	4
I feel embarrassed over his/her behavior	0	1	2	3	4
I feel ashamed of him/her	0	1	2	3	4
I resent him/her	0	1	2	3	4
I feel uncomfortable when I have friends over	0	1	2	3	4
I feel angry about my interactions with him/her	0	1	2	3	4
I don't get along with other family members as well as I used to	0	1	2	3	4
My caregiving efforts aren't appreciated by others in my family	0	1	2	3	4
I've had problems with relationships	0	1	2	3	4
I don't get along as well as I used to with others	0	1	2	3	4

I feel resentful of other relatives who could but do not help

0 1 2 3 4



Dementia/Alzheimer's Grant Application  
for Respite Voucher  
**Section 1**

**Return to:**  
DEAP  
2200 Box Elder Suite 151  
Miles City, MT 59301  
attn: Vicki Clear

**Care Recipient Information**

These questions are about the person who is to be cared for.

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Gender:**  Male  Female **Is the care recipient a veteran?**  Yes  No

**Race:**  Native American or Alaska Native  Asian or Asian American

Black/African American  Native Hawaiian or Pacific Islander  White

**Ethnicity:**  Hispanic or Latino **# of people in household** \_\_\_\_\_

**About the Care Recipient – answer all that apply:**

- Alzheimer's Diagnosis  Traumatic Brain Injury
- Other Dementia Diagnosis (list type) \_\_\_\_\_
- Undiagnosed Dementia  Seizures – type \_\_\_\_\_
- Unable to be Left Unattended
- Other comments: \_\_\_\_\_

**Living Arrangement:**  Alone  With spouse only  With spouse & other relatives

With other relatives  With Grandparent(s)  With non-relative  With parent(s)

With son or daughter  With grandchild  With brother or sister

**My primary caregiver is my:**  Wife  Husband  Daughter  Son  Brother  
**(Check only one)**

Sister  Daughter/Son (in-law)  Mother  Father  Grandchild

Other Relative  Non-Relative (specify) \_\_\_\_\_

## Section 2

### Primary Caregiver Information

These questions are about the caregiver – the person who does the daily caregiving.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Are you a veteran?  Yes  No

Race:  Native American or Alaska Native  Asian or Asian American

Black/African American  Native Hawaiian or Pacific Islander  White

Ethnicity:  Hispanic or Latino

Number of hours the caregiver is responsible for care recipient in an average week: \_\_\_\_\_

Type of services I'm interested in for the care recipient:

In-home hourly care  Temporary overnight care  Adult Day Care

Social Outing  Crisis Care  Other \_\_\_\_\_

Resource(s) that would make respite possible: \_\_\_\_\_  
(such as: door alarm, ID bracelet with address, etc.)

*Call the Alzheimer's Association 24/7 Help Line at 800-272-3900 for more resource ideas.*

*I certify, under penalty of perjury, that the information provided in this application is true and accurate.*

Signature of Caregiver: \_\_\_\_\_

Date: \_\_\_\_\_

**\*\*\*Where did you hear about this respite voucher program:**

\_\_\_\_\_

Directions for filling out the application are at the end of the application.



Return to:  
DEAP  
2200 Box Elder Suite 151  
Miles City, MT 59301  
attn: Vicki Clear

Application for Respite Voucher  
**Section 1**

**Care Recipient Information**

These questions are about the person who is to be cared for.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender:  Male  Female Is the care recipient a veteran?  Yes  No

Race:  Native American or Alaska Native  Asian or Asian American

African American  Native Hawaiian or Pacific Islander  White/Caucasian

Ethnicity:  Hispanic or Latino # of people in household \_\_\_\_\_

**About the Care Recipient – answer all that apply:**

Medical/Mental Health Diagnosis: \_\_\_\_\_

Disability: \_\_\_\_\_

Unable to be Left Unattended: \_\_\_\_\_

Other: \_\_\_\_\_

Living Arrangement:  Alone  With spouse only  With spouse & other relatives

With other relatives  With Grandparent(s)  With non-relative  With parent(s)

With son or daughter  With grandchild  With brother or sister

My caregiver is my:  Wife  Husband  Daughter  Son  Brother  Sister

Daughter/Son (in-law)  Mother  Father  Grandchild  Other Relative

Non-Relative (specify) \_\_\_\_\_

## Section 2

### Primary Caregiver Information

These questions are about the caregiver – the person who does the caregiving.

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Apt:** \_\_\_\_\_  
(If caregiver does not live with care recipient, please provide proof of address)

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Gender:**  Male  Female **Are you a veteran?**  Yes  No

**Race:**  Native American or Alaska Native  Asian or Asian American

African American  Native Hawaiian or Pacific Islander  White/Caucasian

**Ethnicity:**  Hispanic or Latino

**Number of hours the caregiver is responsible for care recipient in an average week:** \_\_\_\_\_

**Type of services I'm interested in for the care recipient:**

In-home hourly care  Temporary overnight care  Adult Day Care

Social Outing  Crisis Care  Other \_\_\_\_\_

I need more information about choices: \_\_\_\_\_

**Are you receiving any respite services now?** (anything that could be considered a break from caregiving)

Yes – If yes, what service(s)? \_\_\_\_\_  No

**Agency or Program:** \_\_\_\_\_ **Funding Source:** \_\_\_\_\_

### Regular Care Provided by Primary Caregiver

As the caregiver for this individual, I regularly (daily/weekly) assist him/her with the following: (check all that apply)

#### **Basic Activities of Daily Living:**

- Personal hygiene bathing/grooming
- Feeding
- Dressing and undressing
- Toileting
- Bowel and bladder management – including incontinence care
- Transferring/walking (moving from bed to wheelchair, getting on and off toilet)

#### **Inability of Care Recipient to perform:**

- Housework
- Meal preparation
- Medication management
- Shopping
- Money management
- Transportation
- Using the telephone and other communication devices

#### **Special Health Care:**

- Medical equipment (oxygen, feeding tube, respiratory equipment, etc.)
- Medication (prescribed, ongoing)
- Nursing assistance (visits regularly)
- Diabetes (insulin dependent/special diet)
- Use of wheelchair, cane, crutches, braces, or walker
- Incontinence – How often? \_\_\_\_\_
- Other specialized care needs \_\_\_\_\_

#### **Care Recipient has difficulty:**

- Seeing
- Hearing
- Communicating
- Comprehending

#### **The Care Recipient has the following specific conditions:**

- Aggressiveness
- Diabetes
- Acting out/impulsive
- Alzheimer's
- Dementia
- Autism
- Traumatic Brain Injury
- Mental Health Issues
- Seizures – Type \_\_\_\_\_

#### **Homebound (cannot leave home without considerable assistance):**

- Yes
- No



## Income Information

In order to determine our level of cost sharing please...

**Complete Section A if you are caring for someone 18 or older**

OR

**Complete Section B if you are caring for someone under 18 years old**

In the appropriate box list **all** Income – Taxable and non-taxable  
(Married couples must report their combined income)

Please check one: Income below is from the past:     **Year**                       **90 days**

**Section A: Care Recipient (and Spouse) Income Information if the Care Recipient is 18 or older:**

<b>All Income Reported on Tax Return</b> (As reported annually to the IRS)	\$
<b>Social Security/SSI/SSDI</b> (If not reported on tax return)	\$
<b>Other Income</b> (If not reported on tax return)	\$

**Section B: Caregiver Income Information if the care recipient is under 18 years old:**

**\*\*\*\*\*Number of dependents living in household (including yourself/spouse):** \_\_\_\_\_

<b>All Income Reported on Tax Return</b> (As reported annually to the IRS)	\$
<b>Social Security/SSI/SSDI</b> (If not reported on tax return)	\$
<b>Other Income</b> (If not reported on tax return)	\$

**Attach documentation for all income listed above.**

## Medical Expenses

No matter which of the above Income Information sections you filled out, please include information about your medical expenses, if applicable. By submitting your Medical Expenses, we may be able to reduce your co-pay.

**Medical Expenses – Please enter the amount of medical expenses paid over the past:**

Year \$ \_\_\_\_\_ **OR** 90 Days \$ \_\_\_\_\_

Please refer to the Medical Expenses portion of the Application Instructions for details on eligible medical expenses.

### You **MUST** send the following items with your application:

- Proof of Primary Caregiver’s Address (if living separate)
- Proof of Care Recipient’s Age
- Income Verification
- Medical Expense Verification (if any)
- Modified Caregiver Strain Index

*I certify, under penalty of perjury, that the information provided in this application is true and accurate.*

**Signature of Caregiver:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**\*\*\*Where did you hear about this respite voucher program:**

\_\_\_\_\_

## Application Instructions

To avoid any delay in processing application, please complete the **entire** application and include appropriate documentation. Application must be signed **by the primary caregiver**.

### **SECTION 1 – COMPLETE FOR CARE RECIPIENT INFORMATION:**

**Date of Birth:** Acceptable proof includes a copy of the care recipient's birth certificate, driver's license, or State ID card.

**Medical/Mental Health Diagnosis:** Give a brief description of the medical or mental health diagnosis in the space provided on the application.

### **SECTION 2 – COMPLETE FOR CAREGIVER INFORMATION:**

Proof of the primary caregiver's address must be included with this application. Acceptable proof includes a copy of the caregiver's current driver's license, State ID card or a utility bill.

**Income Information:** If care recipient is ***over the age of 18 years*** old the amount of cost share is based on the income of the care recipient and spouse, if applicable. If the care recipient is ***under the age of 18***, the cost share is determined by the household income.

**Income Verification Requirements:** All income must be reported and verified. Married couples living together must report and verify income of both spouses. Acceptable proof includes a copy of your most recent Income Tax Return, 1099 statements, Social Security award letter, pension checks, or bank statements. If applicable, include proof of interest, dividends, rental income, stocks and bonds.

If your tax return does not list your Social Security income (Form 1040A line 13a or Form 1040 line 20a) or if you do not file a tax return, you must send us a benefit award letter or bank statement providing how much Social Security and other income you received.

**Other Income:**

If you do not file an income tax return, the "Other Income" box is for pensions or other income that is not taxable but is considered income.

**Medical Expenses:** Ongoing paid medical expenses are deducted from your monthly income which reduces your countable income and may reduce your share of cost. Individuals applying on the basis of the last calendar year's income may report medical expenses paid during the previous 90 days.

Medical expenses include paid bills from physicians, dentists, vision and hearing specialists and other health care professionals, medical insurance including Medicare premiums and deductibles, ambulatory health care facilities, prescription medicines, institutional care, dental, vision and hearing devices, prosthetic and auxiliary apparatus. Proof of claimed medical expenses must be included with your application. Acceptable proof includes copies of paid receipts from your health insurance plan, receipts or print-outs of paid pharmacy bills or any other paid medical bills.

## The Modified Caregiver Strain Index (MCSI)

By Lisa L. Onega, PhD, RN, Radford University School of Nursing

**WHY:** Informal supporters provide the majority of long-term care to chronically disabled older adults. Caregiving has been recognized as an activity with perceived benefits and burdens. Caregivers may be prone to depression, grief, fatigue, financial hardship, and changes in social relationships. They may also experience physical health problems (Thornton & Travis, 2003). Perceived caregiver strain has been associated with premature institutionalization for care recipients along with reports of unmet needs. Screening tools are useful to identify families who would benefit from a more comprehensive assessment of the caregiving experience.

**BEST TOOL:** The Modified Caregiver Strain Index (MCSI) is a tool that can be used to quickly screen for caregiver strain with long-term family caregivers. It is a 13-question tool that measures strain related to care provision. There is at least one item for each of the following major domains: Financial, Physical, Psychological, Social, and Personal. This instrument can be used to assess individuals of any age who have assumed the caregiving role for an older adult. The Modified Caregiver Strain Index (MCSI) is a more recent version of the Caregiver Strain Index (CSI) developed in 1983. The MCSI was modified and developed in 2003 with a sample of 158 family caregivers providing assistance to older adults living in a community-based setting. Scoring is 2 points for each 'yes' and 1 point for each 'sometimes' response. The higher the score, the higher the level of caregiver strain (Travis et al., 2003; Thornton & Travis, 2003).

**VALIDITY AND RELIABILITY:** The internal reliability coefficient is slightly higher ( $=.90$ ) than the coefficient originally reported for the CSI in 1983 ( $=.86$ ). Two-week retest data for one-third of the caregiving sample ( $n=53$ ) was available and resulted in a test-retest reliability coefficient of .88 (Thornton & Travis, 2003).

**STRENGTHS AND LIMITATIONS:** The MCSI is a brief, easy to use, self-administered instrument. Long-term family caregivers were not comfortable with the dichotomous choice on the CSI; the modified instrument provides the ability to choose a middle category response best suited to some situations (Travis et al., 2003). The MCSI clarifies and updates some of the items on the original instrument. The tool is limited by lack of a corresponding subjective rating of caregiving impact. Caregiver strain scores are not categorized as low, moderate, or high, so professional judgment is needed to evaluate by total score the level of caregiver strain. The tool effectively identifies families who may benefit from more in-depth assessment and follow-up.

**FOLLOW-UP:** The higher the score on the MCSI, the greater the need for more in-depth assessment to facilitate appropriate intervention. Additional items and further efforts to develop and test a set of subscales could enhance the applicability of the instrument for research and practice. The older adult care recipient's cognitive status and problematic behaviors should be assessed, as well as the caregiver's perception of role overload or deprivation in key relationships, goals, or activities. Family conflict, work role-caregiving conflict, financial strain, and caregiver social support are also important variables in the overall caregiving experience. Additional work with highly strained long-term caregivers who are receiving little or no formal services is indicated.

### MORE ON THE TOPIC:

Best practice information on care of older adults: [www.ConsultGerIRN.org](http://www.ConsultGerIRN.org).

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# Modified Caregiver Strain Index

**Directions:** Here is a list of things that other caregivers have found to be difficult. Please put a checkmark in the columns that apply to you. We have included some examples that are common caregiver experiences to help you think about each item. Your situation may be slightly different, but the item could still apply.

	Yes, On a Regular Basis=2	Yes, Sometimes =1	No=0
<b>My sleep is disturbed</b> (For example: the person I care for is in and out of bed or wanders around at night)	_____	_____	_____
<b>Caregiving is inconvenient</b> (For example: helping takes so much time or it's a long drive over to help)	_____	_____	_____
<b>Caregiving is a physical strain</b> (For example: lifting in or out of a chair; effort or concentration is required)	_____	_____	_____
<b>Caregiving is confining</b> (For example: helping restricts free time or I cannot go visiting)	_____	_____	_____
<b>There have been family adjustments</b> (For example: helping has disrupted my routine; there is no privacy)	_____	_____	_____
<b>There have been changes in personal plans</b> (For example: I had to turn down a job; I could not go on vacation)	_____	_____	_____
<b>There have been other demands on my time</b> (For example: other family members need me)	_____	_____	_____
<b>There have been emotional adjustments</b> (For example: severe arguments about caregiving)	_____	_____	_____
<b>Some behavior is upsetting</b> (For example: incontinence; the person cared for has trouble remembering things; or the person I care for accuses people of taking things)	_____	_____	_____
<b>It is upsetting to find the person I care for has changed so much from his/her former self</b> (For example: he/she is a different person than he/she used to be)	_____	_____	_____
<b>There have been work adjustments</b> (For example: I have to take time off for caregiving duties)	_____	_____	_____
<b>Caregiving is a financial strain</b>	_____	_____	_____
<b>I feel completely overwhelmed</b> (For example: I worry about the person I care for; I have concerns about how I will manage)	_____	_____	_____

[Sum responses for "Yes, on a regular basis" (2 pts each) and "yes, sometimes" (1 pt each)]

**Total Score =**

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