

**South Carolina Respite Coalition
CAREGIVER SELF-ASSESSMENT**

MAIL, EMAIL OR FAX ALL 5 FULLY COMPLETED* PAGES TO: P.O. Box 493, Columbia, S.C. 29202
 respite@screspitcoalition.org FAX 803.935.5229

* NOTE: We need all the information and reserve the right to reject incomplete applications

| How are YOU doing? | Never | rarely | Some times | often |
|---|-------|--------|------------|-------|
| 1. I feel my health is worse and I am getting sick more. | | | | |
| 2. My sleep is affected by stress and responsibility. | | | | |
| 3 My social life has suffered due to care giving. | | | | |
| 4. I get everything done I need to in a typical day. | | | | |
| 5. I have trouble keeping my mind focused. | | | | |
| 6. I am irritable or angry more than I used to be. | | | | |
| 7. I cry often. | | | | |
| 8. I resent that my loved one needs so much. | | | | |
| 9. I feel lonely. | | | | |
| 10. I feel like I have nowhere to turn for help. | | | | |
| 11. It is very difficult to get away to do something I want to do. | | | | |
| 12. I feel guilt if I leave my loved one with someone else. | | | | |
| 13. My relationships with other family members are suffering because I spend so much time providing care. | | | | |
| 14. I feel no one can take care of my loved one as well as me. | | | | |

What do you hope to get from having this voucher for respite?

- just some time to myself a vacation a good night's sleep
 some time with other family or friends without my loved one with special needs
 catch up some medical and other appointments for me personal care/a bath for my loved one
 other _____

I am a parent of a child under 10. My need for a break is different from that of a "typical" parent because:
