



West Dunbartonshire
Health & Social Care Partnership



Adult Carer Assessment and Support Plan (ACASP)

Supporting Positive Outcomes for Carers

Please send your completed ACASP document to Carers of West Dunbartonshire:

BY POST

Carers Centre
84 Dumbarton Road
Clydebank
G81 1UG

BY EMAIL

acasp@carerswd.org

If you have an allocated Carer Support Worker, your ACASP can also be sent to their direct email address.

Visit www.carerswd.org/meet-the-team for all staff contact details

ABOUT ME

Title:

Forename:

Surname:

Prefer to be known as
(If different to forename):

Gender
(If "Other", please
specify):

MALE

NON-BINARY

FEMALE

OTHER

Preferred Pronouns
(If "Other", please
specify):

SHE/HER

THEY/THEM

HE/HIM

OTHER

Date of Birth (dd/mm/yyyy):

Address:

Mobile No.:

Email Address:

Do you require any support with communication (e.g. an interpreter or BSL support, etc.)?
(If 'Yes', please describe support required)

YES

NO

How did you find out about support for carers?

The following information is being sought for two reasons: the first is that your responses might help shape the support provided to you in the future. The second is to help ensure our services are delivered in a non-discriminatory way; that people are treated fairly. Each of the below are known as Protected Characteristics in the Equalities Act 2010.

DISABILITY STATUS

ETHNICITY

**MARITAL AND CIVIL
PARTNERSHIP
STATUS**

**RELIGION OR
BELIEFS**

SEX

**PREGNANT OR GIVEN
BIRTH IN THE LAST
26 WEEKS**

**SEXUAL
ORIENTATION**

**IS THE GENDER YOU
IDENTIFY WITH THE
SAME AS YOUR SEX
REGISTERED AT
BIRTH?**

Do you have any pre-existing physical and / or mental health conditions (not necessarily related to caring) that you would like to tell us about? (If 'Yes', please select from the list below)

YES

NO

STRESS AND ANXIETY

OTHER MENTAL HEALTH (E.G. DEPRESSION)

LONG TERM CONDITION

CANCER

HEART CONDITION

SENSORY IMPAIRMENT

LEARNING DIFFICULTY

Any other information you'd like to tell us about this/these conditions?

ABOUT THE PERSON/PEOPLE I CARE FOR

Forename:

Surname:

Date of Birth (dd/mm/yyyy):

Address:

Relationship to the person you care for:

What conditions affect the person you care for?:

Is the person you care for affected by a terminal illness?:

YES

NO

Has the person you care for received an assessment of their health and social care needs?:

YES

NO

If 'Yes', were you satisfied with your level of involvement in this?:

YES

NO

If 'No', would you/they want an assessment of their health and social care needs?

(Please ensure you have spoken to the person you care for or know their views on this before answering this question. Saying 'Yes' here will involve a member of staff getting in touch with you to discuss further)

YES

NO

In addition to the person you care for being referred to above, do you care for another person or people?

(If 'Yes', a member of staff will contact you to discuss further)

YES

NO

ABOUT MY CARING ROLE

The person I care for lives with me

YES

NO

I have been caring for:
(Please state how long you have been caring for the person you look after)

On average, every week I care for approximately:
(Please state the length of time you care for each week in hours)

My caring role includes:
(Please tick all that apply)

Helping with medication

Helping with personal care

Helping with shopping and domestic tasks, e.g. cooking, cleaning, ironing, etc.

Helping with transport

Providing emotional support and supervision

Helping with finances and/or other household tasks

Providing support with arranging appointments and/or communicating with practitioners

I am an appointee

I have Welfare Guardianship

I have Financial Guardianship

I have Welfare Power of Attorney

I have Financial Power of Attorney

I am a named person

None of the above

Would you like any information or advice on any of the above?
(If 'Yes', please note what you'd like information on)

YES

NO

Please describe any services or support you currently receive to help with your caring role

What matters to you about having a life alongside your caring role?

What matters to you about your caring role?

THE IMPACT OF CARING

Caring for someone can have varying impacts on a person's life. For some, it can have no impact, while for others the impact can be across their life and to a considerable or critical extent. Please use the opportunity below to record how caring impacts on your life and refer to the assessment guidance document for examples of how caring can impact on someone's life and more information on the different categories used to rate the impact. For each life area where the impact of caring is "low" (as per the guidance) or more, please provide details. Where there is no impact, please record "No Impact" in the "Impact" column.

LIFE AREAS

DETAILS

IMPACT OF CARING

My physical health

My emotional wellbeing

My finances

My life balances

My future planning

My employment and/or life learning

My living environment

**If you have had contact with health, social care staff or other practitioners, have you felt your knowledge and expertise were valued?
(Please use the text box below if you wish to say more about your knowledge and expertise being valued)**

YES

NO

In your current circumstances, do you feel able to continue in your caring role?

YES

YES WITH SUPPORT

NO

In your current circumstances, are you willing to continue in your caring role?

YES

YES WITH SUPPORT

NO

INITIAL SUPPORT PLANNING

If you think you require support in your caring role:

- **What would be the purpose of this?**
- **What outcomes would you like to achieve?**
- **Which area of your life would these be achieved?**
- **What would ideal support involve?**

TICK IF APPROPRIATE	LIFE AREA	IDEAL SUPPORT WOULD INVOLVE	HOW WOULD THIS LIFE AREA IMPROVE IF SUPPORT WAS PROVIDED (OUTCOMES)?
	My physical health		
	My emotional wellbeing		
	My finances		
	My life balance		
	My future planning		
	My employment and/or life learning		
	My living environment		

PLANNING FOR EMERGENCIES

In the event that you faced an emergency and were unable to provide care for the person you care for, how would they be supported?
Please provide details below:

If you are unable to answer the above, would you like to discuss emergency planning with a member of staff?

YES

NO

OTHER SUPPORT

The information you have given will help us to know what kind of support, if any, you would benefit from. In addition, we would like to invite you to consider whether you would benefit from any of the following:

BENEFIT MAXIMISATION CHECK

This is to help ensure you are receiving any and all benefits you may be entitled to

YES

NO

SHORT BREAK

A short break is any form of service or assistance which enables you to have periods away from your caring routines and responsibilities. Short breaks are considered on an individual basis following completion of an Adult Carer Support Plan. Click [here](#) for some examples of how short breaks have been used in West Dunbartonshire and for other examples across Scotland. Please tell us if you'd like to discuss the possibility of a short break

YES

NO

ADVOCACY

Advocacy support can be provided where you think you require support to express your views and help ensure your rights are exercised. Please confirm if you'd like to be referred to advocacy services

YES

NO

SELF-DIRECTED SUPPORT (SDS) (Where Applicable)

Where the impact of caring exceeds the threshold set out in the eligibility criteria (i.e. where the impact on any life area is 'considerable' or higher), a carer becomes eligible for SDS for that need/life area. You can find more information on SDS [here](#). SDS Ideas is a local organisation set up to help people understand and use SDS. Their website can be accessed [here](#). When a member of staff reviews this assessment with you, where appropriate, they will explain the four SDS options and help you decide which one is best for you.

SERVICE CONTACT DETAILS



CARERS OF WEST DUNBARTONSHIRE

Tel: 0141 941 1550
Visit: www.carerswd.org
Email: clydebankcc@carerswd.org

West Dunbartonshire
Health & Social Care Partnership

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERHSIP

Tel: 01389 737 000
Visit: www.wdhscp.org.uk



Y SORT IT

Tel: 0141 941 3308
Visit: www.ysortit.com



WORKING4U

Tel: 01389 738 296
Visit: www.west-dunbarton.gov.uk/jobs-and-training/working4u



LOMOND AND ARGYLL ADVOCACY SERVICE

Tel: 01389 726 543
Visit: www.laas.org.uk



SHARED CARE SCOTLAND

Tel: 01389 622 462
Visit: www.sharedcarescotland.org.uk



SDS IDEAS

Tel: 0141 952 5758
Visit: www.sdsideas.co.uk



CITIZENS ADVICE BUREAU

Tel: 0800 484 0136
Visit: www.wdcab.co.uk



SOCIAL SECURITY SCOTLAND

Tel: 0800 182 2222
Visit: www.socialsecurity.gov.scot



HOME ENERGY SCOTLAND

Tel: 0808 808 2282
Visit: www.homeenergyscotland.org

FURTHER SECTIONS FOR STAFF USE ONLY

ASSESSMENT DETAILS

(For Office Use Only)

Form Start Date (dd/mm/yyyy):

Date ACSP was offered
(dd/mm/yyyy):

Date ACSP was accepted
(dd/mm/yyyy):

Date ACSP was requested
(dd/mm/yyyy):

Is this an initial or review assessment and support plan?

INITIAL

REVIEW

Referral Source:

Name of Assessor:

Designation/Job
Title of Assessor:

Organisation and
Team of Assessor:

Carer's *CareFirst* ID:

Carer's CHI Number:

If the carer has identified that support is required with their communication, please describe how this has been addressed:

If the carer has said an assessment is required for the cared for person, confirm this has been actioned by noting where the referral was made to and the date the referral was made:

WHERE?:

DATE (dd/mm/yyyy)?:

If the carer has requested additional information or advice in the 'My Caring Role' section, please confirm this information has been provided to the carer by noting the date the information was provided (dd/mm/yyyy):

If the carer has requested support with emergency planning, confirm this discussion has taken place by entering the date it took place (dd/mm/yyyy):

If the carer has requested benefit maximisation support, confirm referral has been made to Working4U by entering the date the referral was made (dd/mm/yyyy):

If the carer has requested a discussion regarding short breaks, please record the date this discussion took place (dd/mm/yyyy):

If the carer has requested advocacy support, confirm this referral has been made by entering the date the referral was made (dd/mm/yyyy):

ASSESSED NEEDS, ELIGIBILITY AND SERVICE PROVISION (For Reporting Purposes)

LIFE AREA

ASSESSED NEED

LEVEL OF IMPACT/
ELIGIBILITY CRITERIA

SUPPORT
IDENTIFIED/
NEED MET

My physical health

My emotional
wellbeing

My finances

My life
balance

My future planning

My employment
and/or life
learning

My living
environment

INSERT IRF 1 HERE (IF CARER IS LOOKING TO ACCESS SDS OPTIONS)