

## LAY-PERSON STATEMENT

Your name \_\_\_\_\_

Name of the disabled person \_\_\_\_\_

Your relationship to the disabled person? \_\_\_\_\_

How often do you see the disabled person? \_\_\_\_\_

When you see the disabled person, how many hours do you spend with them? \_\_\_\_\_

When you see the disabled person, what are they doing?

When you see the disabled person, what mental health symptoms do they have?

When you see the disabled person, do they have difficulty **concentrating/staying on task**?

When you see the disabled person, do they have difficulty **dealing with other people**?

When you see the disabled person, what % of the time are they **unable to leave the house**?

☐ 10%   ☐ 20%   ☐ 30%   ☐ 40%   ☐ 50%   ☐ 60%   ☐ 70%   ☐ 80%   ☐ 90%   ☐ 100%

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Signature

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Date