



Dear Caregiver:

Alzheimer's Arkansas is pleased to provide you with information about the **Family Caregiver Support Program**. Funding for this program is provided by the Older Americans Act, National Family Caregiver Support Program, Title III-E Funds. These funds were awarded to CareLink (the Central Arkansas Area Agency on Aging) for distribution throughout the six counties in their service area (Pulaski, Saline, Monroe, Prairie, Lonoke, or Faulkner). CareLink selected Alzheimer's Arkansas Programs and Services to administer the program.

This grant can ONLY be used for RESPITE CARE, which is defined as a short-term break for the caregiver. Respite care may be provided in the home, adult day care center, nursing home or assisted living facility.

Requirements: the care recipient (patient) must

- be 60 years of age or older
- live in the CareLink service area of Pulaski, Saline, Monroe, Prairie, Lonoke or Faulkner counties
- be certified by his/her physician to have a chronic illness and therefore have a need for caregiver services. The patient does not have to be diagnosed with dementia
- not receive the same type of service (home care, day care, facility respite) funded by any other source including, but not limited to private insurance, Medicaid, ElderChoices, Supplemental Security Income, Medicare or hospice

The grant will not be effective until after you receive an approval letter from our office—no services will be paid prior to the approval date. After the grant is approved, **you will have 3 months to use the funds**. If you have not used the funds, you will lose the grant and it will be reassigned. We apologize for any inconvenience this may cause, but it is necessary because of our limited funds.

Please do not hesitate to call me if you have questions.

Sincerely,
Barbara Jensen
Grants Coordinator



**Family Caregiver Support Program
Application for Assistance
(Grant Year 7/01/11 – 6/30/12)**

Grant # A11- _____
CG _____
CR _____
CP _____
Ref _____
Office Use Only

Please Fill Out All Information Required and PRINT CLEARLY; Incomplete Applications will be RETURNED

If you have not used this grant within 3 months from your approval date, you will lose the grant

Step 1 **Caregiver** Full Name _____ Relationship: _____
[The caregiver is the person taking responsibility for the care recipient]

Mailing Address _____
(PO Box, Street Name, Apartment Number)

Home () _____
Cell () _____
(City) (County of Residence) (Zip Code) (Area Code) (Telephone)

Physical Address _____
(If different from above mailing address)

Email Address _____

Gender: ___Female ___Male SSN # ___/___/___ Date of Birth ___/___/___

<u>Marital Status</u>	<u>Ethnicity - Check One</u>	<u>Ethnic Races - Check One</u>
___ Widowed	___ Hispanic or Latino	___ White, non-Hispanic
___ Married	___ Not Hispanic or Latino	___ Black/African American
___ Divorced	___ Unknown	___ American Indian/Native American
___ Single		___ Asian
___ Legally Separated		___ Hispanic ___ Other

Step 2 **Has the care recipient (patient) received this grant before? Yes or No**

Care Recipient's [Patient] Full Name _____

Care Recipient's [Patient] Address, if different from **Caregiver's** address above:

Mailing Address _____
(PO Box, Street Name, Apartment Number)

City _____ Home () _____
(County of Residence) (Zip Code) (Area Code) (Telephone)

Physical Address _____
(If different from above)

Gender: ___Female ___Male SSN # ___/___/___ Date of Birth ___/___/___

<u>Marital Status</u>	<u>Ethnicity Check One</u>	<u>Ethnic Races Check One</u>
___ Widowed	___ Hispanic or Latino	___ White, non-Hispanic
___ Married	___ Not Hispanic or Latino	___ Black/African American
___ Divorced	___ Unknown	___ American Indian/Native American
___ Single		___ Asian
___ Legally Separated		___ Hispanic ___ Other

Care Recipients' monthly household income: \$ _____

Total of monthly income of all living in household: \$ _____

Step 3 **PHYSICIAN CERTIFICATION – all applications must be signed by physician**

I certify that the above named patient has a chronic illness and therefore has a need for caregiver services.

Physician's Signature

Date

Please **PRINT** physician's name: _____

Step 4 Does the care recipient [patient] live: alone _____ with family _____ with others _____?

Can the care recipient [patient] perform the following activities of daily living without substantial human assistance (walker or cane is permitted)? Answer yes or no for each one.

Bathing _____ Dressing _____ Grooming _____ Toileting _____ Eating _____ Walking/Transfer _____

Does Care Recipient have Alzheimer's disease or another type of dementia? Yes _____ No _____

Is the Care Recipient homebound? Yes _____ or No _____

If No: _____ Can leave home **without** assistance. _____ Can leave home **with** assistance.

Step 5 Describe your need for services.

Step 6 **Respite care** provides temporary relief to the caregiver who is providing long term care for an individual. It may be provided in and/or outside the person's home to meet an emergency need or as scheduled relief.

What kind of respite care would benefit your family?

_____ In-Home Care _____ Adult Day Care _____ Short Term stay in nursing home or assisted living

Step 7 Does your loved one receive **the same services that you are applying for** from any other funding sources, including, but not limited to: Private health insurance, Medicare, Medicaid, Hospice, ElderChoices, or Supplemental Security Income? _____ NO _____ YES (if YES, please explain)

Step 8 **Care Provider** [the individual or agency that will be providing the care or services for the care recipient]: Please list the name, address, & phone number of the individual or agency who will be providing the service. This is **NOT** the same as the "Caregiver", must be someone who does **NOT** live with the patient and must be over 18 years of age.

Step 9 I have read and completed the above application and, to the best of my knowledge, the information I have provided is correct. I authorize verification of the information provided in this application.

I understand that:

- my grant may be cancelled if I have made any false or incomplete statements in this application, either about myself or on behalf of the recipient
- Alzheimer's Arkansas is not liable for any negligent services by a provider of my choice
- payment will not be made on services completed prior to my application approval date
- I must submit the proper records in order to receive reimbursement
- payment for services is limited to the funds that are available.

Signature of Caregiver

Date

Funding for this program is provided by the Older Americans Act, National Family Caregiver Support Program, Title III E Funds. These funds were awarded to CareLink (the Central Arkansas Area Agency on Aging) for distribution throughout the six counties in their service area (Pulaski, Saline, Monroe, Prairie, Lonoke and Faulkner) and are administered by Alzheimer's Arkansas Programs and Services.

Alzheimer's Arkansas Programs and Services
10411 West Markham, Suite 130 ~ Little Rock, AR 72205
Phone: 501-224-0021 or 800-689-6090
Fax: 501-227-6303

Alzheimer's Arkansas Programs and Services
does not discriminate on the basis of race, color
national origin, sex, religion, age or disability in
employment or the provision of services



Alzheimer's Arkansas Programs and Services Family Caregiver Support Program



Definitions and Report Requirements for Reimbursement

Adult Day Care: Provides respite care in a structured setting for persons who cannot be left alone. There are two types of adult day care models. One is a “health” model in which a registered nurse and/or certified nursing assistants deliver the services. The other is a “social” model where the services offered are similar to those of a regular senior center, but with a more structured program of activities.

Must submit: “Respite Services Log” or an invoice from the adult day care center

Caregiver: The person who is taking the responsibility for the *care recipient*.

Care Provider: The person or agency who is hired by the *caregiver* to provide the care of the patient (*care recipient*). The *provider* may be an in-home worker (individual or agency), an adult day center or a nursing/assisted living facility. The *provider* may not be anyone living with the patient (*care recipient*).

Care Recipient: The patient; the person receiving the care.

Facility Care: A temporary short-term break for the caregiver that is provided in a nursing home or assisted living facility.

Must submit: Invoice from the facility

Home Care: Services are provided in the home and may include home delivered meals, housekeeping services, sitter services and personal care.

Must submit: “Respite Services Log” or invoice from the agency providing the care

Respite Care: A short-term break for the caregiver. Care may be provided in the home, in adult day care center or in a nursing home or assisted living facility.

Must submit: “Respite Services Log” or an invoice from the respite care provider agency

If you have any questions regarding your grant, please do not hesitate to contact me.

Barbara Jensen, Grant Coordinator
(501) 224-0021 or 800-689-6090



Family Caregiver Support Program (Grant Year 7/01/11 – 6/30/12)



Grievance Procedures

Alzheimer's Arkansas Programs and Services clients may file a grievance or seek resolution of a complaint or concern without fear of retaliation or discontinuation of service. Every client and/or caregiver can be assured that they will be treated with dignity and respect.

WHO MAY APPEAL:

Any person (or their caregiver) who is receiving or has applied for services provided directly by Alzheimer's Arkansas Programs and Services Family Assistance Program.

WHAT YOU MAY APPEAL:

Any decision concerning Family Assistance Program services provided by Alzheimer's Arkansas Programs and Services with which you disagree.

WHERE TO SEND YOUR APPEAL OR GRIEVANCE:

Alzheimer's Arkansas Programs and Services
Grievance Review
10411 W. Markham, Suite 130
Little Rock, AR 72205

HOW TO APPEAL:

1. You are encouraged to discuss any concerns with the Alzheimer's employee assigned to handling your initial request. You should request a conference with this employee before formal grievance procedures are initiated.
2. Should this meeting result in an adverse action or decision, you may request, in writing, reconsideration from the Executive Director. This request is to be made within 7 calendar days of the adverse decision.
3. Within 7 calendar days of receipt of your request, the Executive Director will schedule a reconsideration conference to hear your complaint. A decision concerning your reconsideration will be postmarked within 7 days of the conference.
4. If you are not satisfied with the Executive Director's decision, you have 7 calendar days to request, in writing, a formal hearing before the Executive Committee of the Board of Directors.
5. The Executive Committee will notify you within 7 calendar days of the date, time and place of the hearing. You may be present at the hearing, present evidence and witnesses and cross-examine adverse witnesses.
6. Within 7 calendar days of the hearing, the Executive Committee will mail its findings and decision.

NOTE: Upon written, mutual agreement between client and Alzheimer's Arkansas staff, any or all steps of the Grievance Procedure may be omitted and/or time frames extended. If unable to read and/or write, or if you have a language barrier, Alzheimer's Arkansas will assist you in locating necessary assistance to complete the prescribed procedures.