



Family Assistance Program
Application for Assistance
(Grant Year 7/01/08 – 6/30/09)

These grants are funded by the annual Art to Remember Dinner and Auction hosted by the Alzheimer's Arkansas Auxiliary

Please Fill Out All Information Required and Print Clearly or Application will be RETURNED

Caregiver Full Name Relationship:

The caregiver is one taking responsibility for the care recipient

Address Street Name, Apartment Number

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

Gender: Female Male SSN # / / Date of Birth / /

Marital Status Widowed Married Divorced Single Legally Separated
Ethnicity Check One Hispanic or Latino Not Hispanic or Latino Unknown
Ethnic Races Check One Non-Minority (White, non-Hispanic) Black/African American American Indian/Native American Asian White-Hispanic Other

Care Recipient's (Patient) Full Name

Care Recipient's (Patient) Address, if different from Caregiver's address above:

Address Street Name, Apartment Number

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

Gender: Female Male SSN # / / Date of Birth / /

Marital Status Widowed Married Divorced Single Legally Separated Female Head of Household
Ethnicity Check One Hispanic or Latino Not Hispanic or Latino Unknown
Ethnic Races Check One Non-Minority (White, non-Hispanic) Black/African American American Indian/Native American Asian White-Hispanic Other

The following questions will not be used to determine if you receive this grant or not. Your answers will be helpful only to our program planning.

Does the Care Recipient: Live alone? With family? With other than family?

Care Recipients' monthly household income: \$

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

Is the Care Recipient Homebound? Can not leave home without assistance. Can not leave home at all.

PHYSICIAN CERTIFICATION

I certify that the above named patient has been diagnosed with Alzheimer's disease or another form of dementia.

Physician's Signature

Date

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

How did you hear about the Family Assistance Program?

Describe **WHY** you want our services.

What kind of assistance are you applying for?

_____ **Home Care Supplies**

_____ **Legal Services**

_____ **Home Modifications**

_____ **Mental Health Counseling**

_____ **Respite Care:** _____ In-Home Care _____ Adult Day Care _____ Facility Care

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? _____ YES _____ NO

If yes, please explain:

Care Provider: Please list the name, address, & phone number of the individual or agency who will be providing the respite care, legal services, mental health counseling, or home modifications. This is **NOT** the same as the Caregiver. This is the individual or agency that will be providing the care or services for the caregiver.

I have read and completed the above application, and to the best of my knowledge, the information I have provided is correct. I understand that Alzheimer's Arkansas Programs and Services is not liable for any negligent services from a provider of my choice. I also understand that reimbursement and/or payment of services is limited to the funds that are available.

Signature of **Caregiver**

Date