



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



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

Ethnicity Check One

Ethnic Races Check One

___ Widowed

___ Hispanic or Latino

___ Non-Minority (White, non-Hispanic)

___ Married

___ Not Hispanic or Latino

___ Black/African American

___ Divorced

___ Unknown

___ American Indian/Native American

___ Single

___ Asian

___ Legally Separated

___ 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

Ethnicity Check One

Ethnic Races Check One

___ Widowed

___ Hispanic or Latino

___ Non-Minority (White, non-Hispanic)

___ Married

___ Not Hispanic or Latino

___ Black/African American

___ Divorced

___ Unknown

___ American Indian/Native American

___ Single

___ Asian

___ Legally Separated

___ White-Hispanic ___ Other

___ Female Head of Household

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 a chronic illness and therefore has a need for caregiver services.

Physician's Signature

Date

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

How did you hear about the Family Assistance Program?

Describe **WHY** you want our services.

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 do you plan on getting once you are approved for this grant?

____ In-Home Care ____ Adult Day Care ____ Facility Care

Does your loved one receive **respite care** 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:

Respite Care Provider: Please list the name, address, & phone number of the individual or agency who will be providing the respite care. This is **NOT** the same as the Caregiver. This is the individual or agency that will be providing the care while the caregiver takes a break.

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

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), and are distributed by Alzheimer's Arkansas Programs and Services.