PLEASE READ ALL INFORMATION INCLUDED IN THIS GRANT APPLICATION

Dear Caregiver:

Alzheimer's Arkansas is pleased to provide you with information about the ***DHS Lifespan Family Assistance Program*** (FAP). As you may know, the FAP is funded by annual fundraising projects and or Grants filled out by Alzheimer's Arkansas. The grant is limited to the amount of funds available from these events/grants.

The grant will be offered to new grant recipients (those who have not received this grant in our fiscal year 06/01/17 – 05/31/18). This year the amount of the grant is $250 and only one grant will be awarded to a family (for example grants cannot be awarded to both Mom and Dad).

REQUIREMENTS for receiving the DHS Lifespan FAP Grant:

The "Care Recipient" (patient), of any age, must

- Be certified by his/her physician as having been diagnosed with chronic disease or illness that requires a caregiver.
- Reside in Arkansas
- Live at home with family
- Not be receiving the same type of service funded by any other source including, but not limited to, private insurance, Medicaid, AR Choices, Supplemental Security Income, Pace, Medicare or Hospice.

All information on the application must be filled out or it will be denied and returned delaying approval. It usually takes up to 15 business days to process the application.

The grant may be used to pay for respite care services (in-home, adult day care, and/or facility care). This grant may **NOT** be used for such things as medication, utility bills and general household repairs.

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
Development and Resource Manager

ALZHEIMER'S ARKANSAS PROGRAMS AND SERVICES
201 Markham Center Drive • Little Rock, AR 72205-1409
501-224-0021 or 800-689-6090 • Fax: 501-227-6303 • Web site: www.alzark.org

Alzheimer's Arkansas Programs and Services Family Assistance 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 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

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, Development and Resource Manager
(501) 224-0021 or 800-689-6090

DHS Lifespan Family Assistance Program
Application for Assistance
(Grant Year 6/01/17 – 05/31/18)

Grant # L17-_____
CG_____
CR_____
CP_____
Ref_____
Office Use Only

IT WILL TAKE UP TO 15 BUSINESS DAY S TO PROCESS THE APPLICATION

PLEASE FILL OUT ALL INFORMATION REQUIRED AND PRINT CLEARLY; INCOMPLETE APPLICATIONS WILL BE DENIED!

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

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

Date of Birth ____/_____/_____ **How did you hear about the grant**?_____

Marital Status	Ethnicity - Check One	Ethnic Races - Check One
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

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)

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

Physical Address_____
(If different from above)

Gender: ○ Female ○ Male Date of Birth _____/_____/_____

Marital Status	Ethnicity Check One	Ethnic Races Check One
____ 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: $_____ How many live in household _____
Approval of grant is not based on or limited to income.

PLEASE FILL OUT ALL INFORMATION REQUIRED AND PRINT CLEARLY; INCOMPLETE APPLICATIONS WILL BE DENIED!

PHYSICIAN CERTIFICATION: A practicing, certified physician or other qualified healthcare provider must diagnose the patient with a chronic illness and therefore has a need for care provider services. **The date, diagnosis and Dr.'s signature must be included with this application and must be written on the professional's stationary or prescription pad. The Physician Certification MUST accompany the grant application!**

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)? Circle Y for yes or N for no for each one.

Bathing No / Dressing No / Grooming Yes / Toileting No / Eating No / Walking/Transfer No

Is the Care Recipient homebound? Yes_____ or No_____

If No: Can leave home **without** assistance? No or Can leave home **with** assistance? _____

Describe your need for services.

Because of limited funds in the program, we are asking that you first apply for respite care from your local Area Agency on Aging (AAA) Caregiver Assistance program. A copy of the local AAA's with phone numbers and contacts is provided with your application packet.

What kind of assistance are you applying for?

_____**Respite Care**: _____ **In-Home Care** _____ **Adult Day Care** _____**Facility Care** (short term stay)

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, AR Choices, or Supplemental Security Income?

_____NO _____YES **(if YES, please explain)**

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.

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

Alzheimer's Arkansas Programs and Services
201 Markham Center Drive – Little Rock, AR 72205
Phone: 501-224-0021 or 800-689-6090
Fax: 501-227-6303

Alzheimer's Arkansas
Support. Advocate. Care.

AUTHORIZATION TO RELEASE INFORMATION

This completed form MUST accompany the grant application

PATIENT'S NAME: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY NUMBER:_____/_____/_____

I hearby authorize Alzheimer's Arkansas Programs and Services to obtain from the following agency information pertaining to me receiving respite care services. Respite Care Services is considered a short term break for the caregiver and may be provided in the home by an agency or an individual; in an adult day care center or in a short term stay in a nursing home or assisted living facility.

Agency:
Department of Human Services regarding AR Choices or Independent Choices

I understand that my authorization will remain effective from the date of my signature until _____, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____
Signature of Patient / Patient's Designated Representative Date

_____ _____
Witness Date