1) ELIGIBILITY
The care recipient (patient) must

- Be 60 years of age or older
- Live in the Pulaski, Saline, Monroe, Prairie, Lonoke or Faulkner county
- Have a diagnosis of any chronic illness that requires a caregiver
- Not receive like-services funded by other sources (including, but not limited to: private insurance, Medicaid, Medicare, ARChoices, Independent Choices, Supplemental Security Income or Hospice)

2) APPLICATION
To request an application, call 501-224-0021 or 800-689-6090, email grants@alzark.org, or visit ALZark.org/grants to download and print. All fields on the application must be completed, signed and include the doctor’s certification on the professional’s stationary or prescription pad or it will be denied and returned delaying approval. It can take up to 10 business days to process the application. Applications can be mailed to Alzheimer’s Arkansas, 201 Markham Center Drive, Little Rock, AR 72205, emailed to grants@alzark.org or faxed to 501-227-6303.

3) APPROVAL
The grant will not be effective until after you receive an approval letter from Alzheimer’s Arkansas – no services will be paid prior to the approval date. After the grant is approved, you will have 3 months or until June 30, 2019 (whichever comes first) to use the funds. Applications will be taken until May 31, 2020, after that you must wait to apply after July 1, 2020.

4) PAYMENT
This grant does not pay the caregiver to take care of the care recipient (patient). The caregiver must hire a care provider, an individual over 18 years old and does not live with the patient or an agency that will provide the care or services for the patient. The date of service cannot be before your approval date, located on your approval letter. A Respite Service Log is mailed along with the approval letter to use if you hire an individual. Use the log to record the date, number of hours and the hourly rate that is agreed upon by the caregiver and care provider. Please complete a separate service log for each care provider. All information must be filled out and signed by the caregiver and care provider and include the driver’s license of the care provider. If you hire an agency, they can submit an invoice for payment. Make sure the “Make Check Payable To” has the information on who is to receive payment, whether the caregiver is being reimbursed or the care provider is being paid directly. Service Logs and Invoices can be mailed to Alzheimer’s Arkansas, 201 Markham Center Drive, Little Rock, AR 72205, emailed to grants@alzark.org or faxed to 501-227-6303. Payment or reimbursement can take up to 15 business day to process.

Funding for this program is provided by the Older Americans Act, National Family Caregiver Support Program, Title IIE 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
201 Markham Center Drive
Little Rock AR 72205

Alzheimer’s Arkansas does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services.
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CARELINK CAREGIVER SUPPORT GRANT APPLICATION
GRANT YEAR – 7/1/2019 – 6/30/2020
IT MAY TAKE UP TO 10 BUSINESS DAY TO PROCESS THIS APPLICATION

PLEASE COMPLETE ALL FIELDS AND PRINT CLEARLY – INCOMPLETE APPLICATIONS MAY BE DENIED

Caregiver Information:
Full Name: ____________________________
Address: ____________________________
City: ___________________ State: ______ Zip:________
Phone: ____________________________
Email: ____________________________
DOB: ______________ SSN#: __________

Gender:  □ Male □ Female □ Other
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other

Marital Status: □ Widowed □ Married □ Divorced □ Single □ Legally Separated
Ethnic Race: □ White □ Black/African American □ American Indian □ Asian □ Hispanic □ Other

Do you live in a rural area: □ Yes □ No
Do you live alone: □ Yes □ No
Relationship to patient: ____________________________
How many hours per day do you provide care? __________

Care Recipient (Patient) Information:
Full Name: ____________________________
Address: ____________________________
City: ___________________ State: ______ Zip:________
Phone: ____________________________
Email: ____________________________
DOB: ______________ SSN#: __________

Gender:  □ Male □ Female □ Other
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other

Marital Status: □ Widowed □ Married □ Divorced □ Single
Ethnic Race: □ White □ Black/African American □ American Indian □ Asian □ Hispanic □ Other

Does the patient live in a rural area: □ Yes □ No
Does the patient live alone: □ Yes □ No
Diagnosis: ____________________________________________
County Care Recipient Resides In _______________________

DIAGNOSIS CERTIFICATION: THE DIAGNOSIS FROM A QUALIFIED HEALTHCARE PROVIDER MUST INCLUDE PATIENT NAME, DATE OF BIRTH, AND DIAGNOSIS ON AN OFFICIAL LETTERHEAD OR PRESCRIPTION PAD.

For what kind of assistance are you applying:
□ In Home Care □ Adult Day Care □ Short Term Facility Stay □ Other: ____________________________

If using a professional care provider, please provide their contact information for grant approval notification:
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Your privacy is important to us, please visit ALZark.org/grants to view our full privacy statement.
Are there any individuals, other than you, with whom we may share grant information? Please list in the space below:
____________________________________________________________________________________________________
____________________________________________________________________________________________________

How did you hear about this grant: ____________________________

Alzheimer’s Arkansas does not discriminate on the basis of race, color, national origin, gender, sexual orientation, religion, age or disability in employment or the provision of services.
Does the patient receive respite services from any of the following:
- Private Health Insurance
- Medicare
- Medicaid
- Hospice
- ARChoices
- Independent Choices
- CareLink
- PACE
- DHS
- Health Dept
- SSI
- VA

AUTHORIZATION TO RELEASE INFORMATION:

In order to approve your application, we must first confirm your eligibility. I hereby authorize Alzheimer’s Arkansas Programs and Services to obtain from the following agency information pertaining to me receiving respite care services.

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 one year after 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

CAREGIVER SIGNATURE:

I have read the above information and completed the application. The information I have provided is correct to the best of my knowledge. Furthermore, I understand that:

- My grant may be cancelled if I have made any false or incomplete statements on this application, either about myself or on behalf of the patient
- I certify that I am the caregiver for the care recipient
- Alzheimer’s Arkansas and CareLink are 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 fund availability
- It may take up to 10 business days to process my application

__________________________________________________________  ____________________________
Signature of Caregiver  Date

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Alzheimer’s Arkansas
201 Markham Center Drive, Little Rock, AR 72205
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