PLEASE READ ALL INFORMATION INCLUDED IN THIS GRANT APPLICATION

Dear Caregiver:

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

The grant will be offered to new grant recipients (those who have not received this grant in our fiscal year 07/01/17 – 06/30/18). 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 FAP Grant:

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

- Be certified by his/her physician as having been diagnosed with Alzheimer's disease or a related dementia
- 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), home care supplies, home modifications, legal services or mental health counseling. 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,
Belinda Pedigo
Grant Coordinator

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

Legal Counsel: Assistance from an attorney who specializes in elder law issues such as guardianships, power of attorney and living wills.

Must submit: Invoice from the attorney

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

Home Care Supplies/Modifications: Products or services that assist with the care of the patient in the home. May include:

- Home modification such as installing grab bars in the bathroom or installing a wheelchair ramp (does not include general home repairs)
- Dietary supplements like Ensure or Equate – liquid, bars, pudding, etc.
- Baby monitoring system
- Shower chair or stool
- Incontinence supplies such as diapers, wipes, lotions for rash protection, disposable pads or gloves

Must submit: Original sales receipt showing the specific items purchased

Mental Health Counseling: Counseling to help with difficulties in coping with caregiving or coming to terms with the illness. Service providers may include psychiatrists, psychologists, or licensed therapists.

Must submit: Invoice from the mental health provider

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.

Belinda Pedigo, Grant Coordinator
(501) 224-0021 or 800-689-6090

These grants are funded by annual fundraising projects hosted by Alzheimer's Arkansas

Family Assistance Program Application for Assistance (Grant Year 7/01/17 – 6/30/18)

Grant # F17-_____
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 FAP 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 one of the following: "Alzheimer's disease", "probable Alzheimer's disease," dementia of the Alzheimer's type" or "dementia". **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.**

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 Y or N / Dressing Y or N / Grooming Y or N / Toileting Y or N / Eating Y or N / Walking/Transfer Y or N

Is the Care Recipient homebound? Yes_____ or No_____

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

_____**Home Care Supplies** _____**Legal Services** _____**Other (please specify)**

_____**Home Modifications** _____**Mental Health Counseling**

_____**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

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

Family Assistance Program
Policies and Procedures
(Grant Year 7/01/17 – 6/30/18)

KEEP THIS SHEET FOR YOUR RECORDS

Funding for this program is provided by annual fundraising projects hosted by the Alzheimer's Arkansas Auxiliary. The grant is limited to the amount of funds available from these events. 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. After the AAA grant has been closed or you have been denied, you are eligible to apply for the FAP grant.

All information must be filled out on the application or it will be denied and returned which will delay the grant being approved. It takes up to 15 business days to process the application

Who can receive the grant?

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

- Resides in Arkansas
- Live at home with family
- Is certified by his/her physician to have a diagnosis of Alzheimer's disease or a related dementia and therefore have a need for caregiver services. The grant must be signed by physician and stamped with the physician's name and address.
- Does not receive the same type of services (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.
- Services must be received after approval of the application.
- The amount of financial assistance that is give to ONE family is $250.00 per fiscal year.
- Has not received this grant in the past.

How much is the grant?

- The grant is $250.00 per year. Grants are limited to funds available.

How long do I have to spend it?

- **The grant must be used with in 3 months of the approval date, but no later than June 30 of the current fiscal year or you will lose the grant!**

What will the grant pay for?

- The grant may be used to pay for **respite care services** (in-home care, adult day care, facility care). It is the responsibility of the caregiver to choose the service(s) needed.
- Home Care Supplies
- Legal Services
- Home Modifications
- Mental Health Counseling

What will the grant NOT pay for?

- The grant is for families who take care of a chronically ill family member. It cannot be used to give the employee of a respite home/center a vacation.
- This grant may **NOT** be used for such things as: medication, utility bills and general household repairs.

How Does the Grant Pay for Services?

- When a grant is approved, the caregiver will receive a letter from Alzheimer's Arkansas advising them of the amount of funds that are available for use.
- If an agency, adult day care or facility is to be the provider, the provider will also receive a confirmation letter. Friends, family, etc., providing respite care will not receive a letter.
- Services must be purchased after the grant is approved. Fees for services provided prior to grant approval will not be paid.

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

- The agency/person providing the service can bill Alzheimer's Arkansas directly **OR** the caregiver may submit a completed "Service Log" (furnished by Alzheimer's Arkansas) specifying who is to receive the check and Alzheimer's Arkansas will pay the care provider directly or reimburse the caregiver.
- Payment or reimbursement will usually be within 15 business days from the date the Service Log or invoice is received in the Alzheimer's Arkansas office**.**

LIABILITY

Alzheimer's Arkansas Programs and Services cannot make recommendations on which provider to choose and is not liable for services rendered to the patient or caregiver.

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 Caregiver Support Program.

WHAT YOU MAY APPEAL:

Any decision concerning Family Caregiver Support 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
201 Markham Center Drive
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.
7. If you are dissatisfied with this decision, you may contact CareLink and the Arkansas Division of Aging and Adult Services.

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.