2021-2022 CareLink Caregiver Support Grant Application Process

1) ELIGIBILITY

The care recipient (patient) must

- Be 60 years of age or older
- Live in Pulaski, Saline, Monroe, Prairie, Lonoke or Faulkner County
- Live independently or with family (not in a full-time care facility)
- Must have an official diagnosis on doctor's letterhead of any chronic illness that requires the assistance of a caregiver for daily functions. The diagnosis must state the chronic illness, state that the patient requires daily assistance, be signed by the doctor, and dated within a year of submitting the application.

2) APPLICATION

The amount of financial assistance given per grant approval is ***$500***. A family may receive this grant **twice** in a calendar year (July 1st to June 30th), with **6 months** between approval dates. For questions, or to request/download an application, call 501-224-0021, visit ALZark.org/grants, or email grants@ALZark.org. ***A current application dated 7/1/2021 – 6/30/2022 must be submitted.***

3) APPROVAL

All information on the application must be completed, the 2nd page must be signed, and the submission must include a diagnosis on official letterhead or prescription pad (per the instructions under ELIGIBILITY). It may take up to 10 business days to process your application. Applications can be sent via mail, email, or fax (information below). The grant will not be effective until after you receive an approval letter from Alzheimer's Arkansas. After the grant is approved, you will have 3 months or until June 15th, 2022 (whichever comes first) to use the funds. Applications will be accepted until May 31st, 2022, if funds are still available.

4) PAYMENT

A respite service log will be mailed with the approval letter. Use this log to record the date, number of hours, and hourly rate. The hourly rate is to be determined by the caregiver and care provider. **The dates of service must be on or after the approval date indicated on your official approval letter.** The care provider can be a business that provides professional care, *or* any individual over the age of 18, with a government issued ID, who does not live with the patient. **The hired care provider cannot also be the caregiver listed on the application. This grant is intended to pay for or reimburse the cost of relief care.** As indicated on the log, you may request payment to yourself as reimbursement or directly to the care provider. If you hire a business as the care provider, they may submit an invoice directly to Alzheimer's Arkansas for payment. Service logs and invoices can be sent via mail, email, or fax. Payment or reimbursement may take up to 15 business days to process.

5) KEY TERMS

Care Recipient - Person receiving care; the patient
Caregiver – Unpaid primary loved one (person completing application) who assists the care recipient with daily functions
Care Provider - Person who is hired by the family caregiver to provide care to the patient (cannot be the family caregiver)
Respite – A short period of rest or relief from caregiving duties

6) CONTACT INFORMATION

Mail: Alzheimer's Arkansas
201 Markham Center Dr
Little Rock Arkansas 72205

Email: grants@alzark.org

Fax: 501-227-6303

Funding for this program is provided by the Older Americans Act, National Family Caregiver Support Program, Title IIIE 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 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.

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Alzheimer's Arkansas
Caring for Caregivers

CARELINK CAREGIVER SUPPORT GRANT APPLICATION

FOR GRANT YEAR – 7/1/2021 – 6/3/2022

IT MAY TAKE UP TO 10 BUSINESS DAYS TO PROCESS THIS APPLICATION

ALL FIELDS ARE REQUIRED & INCOMPLETE APPLICATIONS MAY BE DENIED.

CareLink
Resources for Older People and Their Families

Caregiver Information (unpaid family/friend caregiver):

Full Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____

Email: _____

DOB: _____ SSN: _____

Gender:
☐ Male
☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Widowed
☐ Married
☐ Divorced
☐ Single

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: _____
Hours of care you provide daily: _____
How did you hear about this grant? _____

Care Recipient (Patient) Information:

Full Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____

Email: _____

DOB: _____ SSN: _____

Gender:
☐ Male
☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Widowed
☐ Married
☐ Divorced
☐ Single

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: _____
Primary Speaking Language: _____
County Care Recipient Resides In: _____

This application must be submitted with a diagnosis on doctor's letterhead of any chronic illness that requires the assistance of a caregiver for daily functions. The diagnosis must state the chronic illness, state that the patient requires daily assistance, be signed by the doctor, and dated within a year of the submitting this grant application.

For what kind of assistance are you applying?

☐ In-home Care ☐ Adult Daycare ☐ Short Term Facility Stay

The caregiver must hire a care provider to provide respite care. The provider can be an individual over 18 years old, who does not live with the patient or an agency/organization that will provide care services for the patient. This grant does not pay the caregiver listed above to perform daily caregiving duties.

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?

_____

201 Markham Center Drive, Little Rock, AR 72205
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grants@alzark.org • ALZark.org/grants

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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
Other:_____

AUTHORIZATION TO RELEASE INFORMATION:
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 and 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 declined/returned to me 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 non-paid primary caregiver for the care recipient.
- Alzheimer's Arkansas Programs & Services and CareLink are not liable for the quality of care, any negligence, or outstanding balances associated with the care provider of my choice.
- I have read the Process page to this application and understand the terms and conditions of receiving this grant.
- Payment will not be made on service completed prior to my application approval date.
- I must submit the proper records to receive reimbursement.
- Payment for services is limited to fund availability.
- It may take up to 10 business days to process my application.

_____ _____
Acceptance & Signature of Caregiver (Unpaid family/friend) Date

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