Family Caregiver Support Program
4 – Step Application Process

1) REQUIREMENTS

The care recipient (patient) must

- Be 60 years of age or older
- Live in the CareLink service area of Pulaski, Saline, Monroe, Prairie, Lonoke or Faulkner counties
- Be certified by his/her physician to have a chronic illness and therefore require a caregiver. The patient does not have to be diagnosed with dementia or Alzheimer's.
- Not receive the same type of service (home care, day care or facility care) funded by any other source including, but not limited to private insurance, Medicaid, Medicare, ARChoices, Independent Choices, Supplemental Security Income or Hospice.

2) APPLICATION

To request an application, call Barbara at 501-224-0021 or 800-689-6090 or email at barbara.jensen@alzark.org. All information on the application must be filled out, 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 15 business days to process the application. Applications can be mailed to Alzheimer's Arkansas, 201 Markham Center Drive, Little Rock, AR 72205, emailed to barbara.jensen@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. 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 due to the limited funds available. The amount of financial assistance that is given to ONE family is $500 per fiscal year (July 1 to June 30).

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 barbara.jensen@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 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 Programs and Services
201 Markham Center Drive
Little Rock AR 72205

FAMILY CAREGIVER SUPPORT PROGRAM APPLICATION FOR ASSISTANCE

GRANT YEAR – 7/1/2018 – 6/30/2019

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

PLEASE FILL OUT ALL INFORMATION REQUIRED AND PRINT CLEARLY

INCOMPLETE APPLICATIONS WILL BE DENIED!

Caregiver Information:

Full Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

DOB: _____ SSN#: _____

Gender:

☐ Male
☐ Female

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

Relationship to patient: _____

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
☐ Other

Marital Status:

☐ Widowed
☐ Married
☐ Divorced
☐ Single
☐ Legally Separated

Ethnic Race:

☐ White
☐ Black/African American
☐ American Indian
☐ Asian
☐ Hispanic ☐ Other

Is Care Recipient's total household monthly net income more than ☐ $980.83 ☐ $1,335 ☐ $1,680

Total number that lives in the household? _____

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 DOCTOR'S SIGNATURE MUST BE INCLUDED WITH THIS APPLICATION AND MUST BE WRITTEN ON THE PROFESSIONAL'S STATIONARY OR PRESCRIPTION PAD!**

SERVICES AND PROVIDER INFORMATION:

This grant is for respite services only, which 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 scheduled relief.

What type of respite care would benefit your family?

☐ In Home Care ☐ Adult Day Care ☐ Short Term Stay in nursing home or assisted living facility

Care Provider is the individual over 18 y/o and does not live with the patient or an agency that is hired to provide the care or services for the patient. Please list the name, address & phone number of the individual or agency who will be providing the care or service. This is not the "caregiver". _____

_____

QUESTIONS ABOUT THE CARE RECIPIENT (PATIENT):

Does the care recipient (patient) live: ☐ Alone ☐ with Spouse ☐ with Children ☐ Other: _____

Can the care recipient (patient) perform the following activities of daily living without substantial human assistance (walker or cane is permitted)? ☐ Bathing ☐ Dressing ☐ Grooming ☐ Toileting ☐ Eating ☐ Walking/Transfer

Is the care recipient homebound? ☐ Yes ☐ No If No, can leave home ☐ with or ☐ without assistance.

Does the care recipient have Alzheimer's disease or another type of dementia? ☐ Yes ☐ No

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

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

IS THE CARE RECIPIENT RECEIVING LIKE SERVICES? Does your loved one receive respite services from any other funding sources, including, but not limited to: ☐ Private Health Insurance ☐ Medicare ☐ Medicaid ☐ Hospice ☐ ARChoices, ☐ Independent Choices ☐ CareLink ☐ PACE ☐ DHS ☐ Health Dep ☐ SSI

If you checked any, please explain what services you are receiving and who pays for the services.

AUTHORIZATION TO RELEASE INFORMATION:

Patient's Name: _____

DOB: _____ SSN: _____

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.

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

_____ _____

Witness Date

CAREGIVER SIGNATURE:

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 on this application, either about myself or on behalf of the patient
- 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

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