



# 2024 Family Assistance Program Grant Application Process

## 1) ELIGIBILITY

The care recipient (patient) must

- Reside in Arkansas
- Live independently or with family (not in a full-time care facility)
- Require the assistance of a caregiver for daily functions (must be stated on the diagnosis)
- Have an official and signed diagnosis letter from a physician's letterhead or prescription pad (the diagnosis must specifically state a form of any Dementia; *mild cognitive impairment is not eligible* or state any chronic illness of care recipient over 60 that requires a caregiver)

## 2) APPLICATION

The amount of financial assistance given per grant approval is **\$500**. A family may receive this grant **twice** (every 6 months from grant approval), **with 90 days to use funding**, if funds are available. For questions, or for an application, call 501-224-0021 EXT 210, visit [alzARK.org/grants](http://alzARK.org/grants), or email [grants@alzARK.org](mailto:grants@alzARK.org). **A current application dated 01/01/2024 – 12/31/2024 must be submitted.**

## 3) APPROVAL

**All information** on the application must be completed, signed, and include a diagnosis letter on an official letterhead or prescription pad. It may take up to 10 business days to process your application. Applications can be mailed to Alzheimer's Arkansas at 201 Markham Center Drive, Little Rock, AR 72205, emailed to [grants@alzARK.org](mailto:grants@alzARK.org), or faxed to 501-227-6303.

## 4) GRANT COVERAGE

Once approved, grant funds may be used for the following items:

- Respite care services (in-home, adult day care, and/or short term stay in a facility)
- Homecare supplies
- Caregiver mental health counseling
- Minor home modifications (with prior approval)
- Senior legal services
- Utility bills (**only**: gas, electric, water/sewage, garbage)
- Other services to reduce caregiver stress (i.e., home cleaning, cooking, yard work, etc.)

## 5) GRANT PAYMENT

Once approved, grant funds will be paid in full via check to the applying caregiver. The check will be sent with the approval letter and a respite log. After receipt of grant check and use of funds, applicants must submit the respite log to our office no later than 90 days after the approval date. (**Failure to return this log and survey will result in the loss of eligibility for all future grants offered by Alzheimer's Arkansas for the caregiver AND care recipient associated with the grant.**) 2024 FAP grant payments will only be made payable to the primary caregiver listed on the application and mailed to the address provided.

*FAP Grants are limited to the amount of funds available and cannot be guaranteed through the entirety of the year. 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.*



# FAMILY ASSISTANCE PROGRAM GRANT (FAP)

FOR GRANT YEAR – 1/1/2024 – 12/31/2024

**ALL FIELDS ARE REQUIRED AND INCOMPLETE APPLICATIONS MAY BE DENIED.**

### Caregiver Information (unpaid family/friend caregiver):

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

DOB: \_\_\_\_\_

#### 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

Hours of care you provide daily: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

How did you hear about this grant? \_\_\_\_\_

### Care Recipient Information (patient, person receiving care):

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_

#### Gender:

Male

Female

#### Ethnicity:

Hispanic or Latino

Not Hispanic or Latino

#### Marital Status:

Widowed

Married

Single

Divorced

#### 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: \_\_\_\_\_

**Copy of diagnosis from your physician must be included.**

### For what kind of Assistance are you applying?

In-home Care  Adult Daycare  Short Term Facility Stay  Homecare Supplies  Home Modifications

Legal Services  Mental Health Counseling  Utility Bill (gas, electric, water/sewage, garbage)

\*\*Any other uses **must** be approved by the grant coordinator prior to grant approval

Your privacy is important to us, please visit [alzARK.org/grants](http://alzARK.org/grants) to view our full privacy statement. Are there any individuals, other than you, with whom we may share grant information? \_\_\_\_\_

### Acknowledgement

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

- My grant may be cancelled if I have made any false or incomplete statements.
- Alzheimer's Arkansas is not liable for any negligent services by the provider of my choice.
- If used for utility payment, Alzheimer's Arkansas is not held liable for any late or reconnection fees.
- Payment will not be made on services completed prior to my application approval date.
- If approved, I will receive a follow-up survey with my approval letter and check that MUST be completed and returned within 3 months through which I will explain how the grant funds were used.
- If I do not complete the follow-up survey, I will no longer be eligible for ANY grants offered by Alzheimer's Arkansas.
- Grant availability is limited to the funds available and are not guaranteed.
- It may take up to 10 business days to process my application & application submissions do not guarantee an approval.
- This grant cannot be used to pay the caregiver applying (above) for their caregiving duties.

\_\_\_\_\_  
Signature of Caregiver

\_\_\_\_\_  
Date