

# Dementia Caregiver Respite Grant Log & Survey

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**AFTER GRANT FUNDS ARE SPENT.** Please submit this Respite Log & Survey **no later than 90 days after your approval date.** The log and survey can be mailed, emailed, faxed, OR texted.

**Care Recipient Name:** \_\_\_\_\_ **Grant #:** \_\_\_\_\_

(Care Recipient is the patient, the person receiving the care.)

DATE OF SERVICE (on or after approval date)	# HOURS		HOURLY RATE	=	DAILY TOTAL	Care <u>Provider</u> Name (The person(s) paid/company hired to provide respite care)
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
		x	\$	=	\$	
<b>TOTALS:</b>						

Multiply # of hours by hourly rate to get the total for the day. **Please submit logs in \$100 or more increments.**

### IMPORTANT INFORMATION – PLEASE READ

IF YOU ARE NOT USING A CARE PROVIDING COMPANY, THE HIRED PROVIDER MUST BE 18 YEARS OF AGE AND OLDER AND NOT LIVING WITH THE CARE RECIPIENT. **A COPY OF EVERY CARE PROVIDER'S DRIVER'S LICENSE MUST BE ATTACHED TO THE SERVICE LOG. (UNLESS AGENCY INVOICE IS ATTACHED)**

**PLEASE COMPLETE POST-FUNDING SURVEY ON THE 2<sup>ND</sup> PAGE →**

Alzheimer's Arkansas Programs and Services

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# Dementia Caregiver Respite Grant

## Post Funding Survey

Please answer and complete the following questions regarding the grant application process. Please be objective – all comments are helpful! The information you provide will help us to better our application process, as well as helping us understand the needs of Arkansas Caregivers. Your answers **do not** affect eligibility for receiving this grant.

Please rate the level ease of the overall grant application process:  1  2  3  4  5  
Easy Difficult

Please rate the level ease of finding a respite provider:  1  2  3  4  5  
Easy Difficult

Please rate the improvement of the overall stress level of the household after utilizing grant funds:  
 1  2  3  4  5  
No Improvement High Improvement

What did this grant funding allow you to accomplish? (i.e., vacation, grocery shopping, mental health, doctor's appointment, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Caregiver PRINTED Name: \_\_\_\_\_  
(Caregiver is the person who applied for this grant.)

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.