Dementia Caregiver Respite Grant

FOR GRANT YEAR – 07/01/2025 – 06/30/2026

Application Process

Please read before applying

1.) ELIGIBILITY

The care recipient (patient):

- Can be of any age and must reside in Arkansas. Living independently or with family **(not in an assisted living or full-time care facility)**
- Must have an official diagnosis on a doctor's letterhead of any form of Dementia. (Alzheimer's, Parkinson's, etc.) The diagnosis must state that the patient requires daily assistance, be signed by the doctor or certified care physician, 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 (every **6 months** between approval dates) based upon funding. Only one grant can be open at a time. The application is a total of four (4) pages, including this page; all pages and questions must be completed and answered for approval. Incomplete applications may be denied.

3.) APPROVAL

The application and pre-survey must be fully completed, signed, and submitted with a diagnosis letter or prescription pad to be considered for approval. (diagnosis letters will stay on file for one year of date on letter) **It may take up to 10 business days to process your application.** Applications can be sent via mail, email, fax, or text. (information below) Alzheimer's Arkansas cannot guarantee the availability of funds throughout the entire grant period. **If your application is approved, you will receive a mailed approval letter, grant check, and a Respite Survey Log which should be returned within 3 months (90 days) of the approval date.**

4.) GRANT COVERAGE

This grant may be used to pay for respite care services **ONLY**. This includes services such as:

- In-Home Care
- Adult Daycare
- Short-Term Facility Stays

THIS GRANT DOES NOT PAY THE CAREGIVER (PERSON COMPLETING THIS APPLICATION) TO PERFORM THEIR DAILY CAREGIVING DUTIES.

5.) GRANT COMPLIANCE AND COMPLETION

If your application is approved, you will receive a *MAILED* approval letter, grant check, and a Respite Survey Log. You *MUST* complete and return the Respite Survey Log within 3 months (90 days) after the approval date. Failure to submit the survey will subject the caregiver to being denied all future grants offered by Alzheimer's Arkansas.

Alzheimer's Arkansas Programs and Services
201 Markham Center Drive, Little Rock AR 72205
Phone: 501-224-0021 EXT 210 | Fax: 501-227-6303 | Email: grants@alzARK.org | Website: alzARK.org

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PLEASE COMPLETE EVERY PAGE (EACH PAGE IS DIFFERENT)

CAREGIVER Information (unpaid person providing care to patient):

Caregiver Legal Name: _____
First Middle Last

Date of Birth: ___ ___ /___ ___ / ___ ___ ___ ___ Age: _____ Gender: ☐ Male ☐ Female
Month Day Year Gender Identity: _____

Physical Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

*Your answers to the following questions **do not** affect eligibility status of receiving this grant; however, each question must be answered.*

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Single
- ☐ Widowed

Military Status:
- ☐ Active Duty
- ☐ Retired
- ☐ Veteran
- ☐ None

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:
- ☐ White
- ☐ Black/African American
- ☐ American Indian
- ☐ Asian
- ☐ Hispanic
- ☐ Other

Relationship to the patient: _____

How many hours of care do you provide daily? _____

How did you hear about this grant? _____

Employment Status: ☐ Employed ☐ Unemployed

Annual Household Income: $_____

Have you received a respite assistance grant in the past 12 months? ☐ Yes ☐ No

If so, from where? _____

For what kind of respite assistance are you applying?

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

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? Please list in the space below:

_____

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CARE RECIPIENT Information (patient, person receiving care):

Care Recipient Legal Name: _____
First Middle Last

Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____ Age: _____ Gender: ☐ Male ☐ Female
Month Day Year Gender Identity: _____

Physical Home Address: _____
City: _____ State: _____ Zip: _____ County: _____

Mailing Home Address: _____
City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

*Your answers to the following questions **do not** affect eligibility status of receiving this grant; however, each question must be answered.*

Marital Status:
☐ Married
☐ Divorced
☐ Separated
☐ Single
☐ Widowed

Military Status:
☐ Active Duty
☐ Retired
☐ Veteran
☐ None

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

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

Patient Diagnosis: _____

Does the patient live alone: ☐ Yes ☐ No

Patient Primary Speaking Language: _____

Has the patient received/currently utilizing any DHS Waiver or State Plan Service Programs? _____

Dementia Caregiver Respite Grants are limited to the amount of funds available. This grant project is funded through the Arkansas Lifespan Respite Coalition and the Administration on Community Living.

NOTE: This application MUST be submitted with a diagnosis letter on doctor's letterhead of any form of Dementia that requires the assistance of a caregiver for daily functions. The diagnosis must state the form of Dementia, state that the patient requires daily assistance, be signed by the doctor, and dated within a year of submitting this grant application. Diagnosis letters can be emailed, faxed, mailed or texted. (All contact information below.)

PLEASE COMPLETE THE PRE-FUNDING SURVEY ON THE LAST PAGE →

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Pre-Funding Survey

Please answer 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 to receive this grant.

Please rate the level of burden paying out-of-pocket for respite care is on your family: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Please rate the level of ease in applying for this grant: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Please rate your current stress level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Have you received respite prior to applying for this grant? ☐ Yes ☐ No

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 denied and/or returned to me if I have made any false or incomplete statements.
- The grant funds may only be used to hire a 3rd party provider (professional or personal) to provide respite. These funds cannot be used to pay myself to provide care to the patient.
- Alzheimer's Arkansas is not liable for any negligent services provided by the care provider of my choice.
- This grant is limited to available funds. Alzheimer's Arkansas may not be able to provide grants throughout the full grant period if allotted funds are used before my application is processed.
- It may take up to 10 business days to process my application.
- I will receive a survey/log with my grant approval, and I will return it upon completion of the services paid for by this grant. If I do not return this survey, I will not be eligible for future grants offered by Alzheimer's Arkansas.

_____ _____

Signature of Caregiver Date

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