Alzheimer's Arkansas Caregiver Grants

FOR GRANT YEAR – 07/01/2026 – 06/30/2027

IT MAY TAKE UP TO 10 BUSINESS DAYS TO PROCESS THIS APPLICATION. ALL FIELDS ARE REQUIRED & INCOMPLETE APPLICATIONS MAY BE DENIED

Application Process

(PLEASE READ BEFORE APPLYING)

1.) ELIGIBILITY

The Care Recipient (patient) must reside in Arkansas, living independently or with family **(not in an assisted living or full-time care facility)**. The patient must have an official diagnosis on a doctor's letterhead of any chronic illness or any form of Dementia (Alzheimer's, Parkinson's, etc.) that requires a caregiver for daily functions. The diagnosis must state the chronic illness, state that the patient requires daily assistance with (ADL) OR (IADL), be signed by the doctor or certified medical practitioner, and be **dated within a year** of submitting the application.

2.) APPLICATION

A family may receive a grant twice in a calendar year (every **6 months** between approval dates) based upon funding. Grants are prioritized by financial need, minority status, and rural residency. **Only one grant can be open at a time.** All pages and fields must be fully completed; incomplete applications may be denied.

3.) APPROVAL & PROCESSING

A completed application, pre-funding survey, last page signed and dated, submitted with a signed diagnosis letter or prescription pad will be considered for approval. (Diagnosis letters will remain on file for one year from the date of the letter.) Applications and diagnosis letters may be sent via mail, email, fax, or text. **It may take up to 10 business days to process your application.**

4.) GRANT COVERAGE

The CareLink Caregiver Support and Dementia Caregiver Respite grants may be used to pay for respite care services **ONLY** — In-Home Care, Adult Daycare, or Short-Term Facility Stays. The Caregiver MUST hire a care provider: any individual 18 years of age or older who does not live with the patient, or a care providing company. The hired provider cannot be the caregiver listed on this application.

CAREGIVER GRANTS DO NOT PAY THE CAREGIVER TO PERFORM THEIR DAILY CAREGIVING DUTIES.

5.) GRANT COMPLIANCE

After approval, you **MUST** complete and return a Respite Service Log & Survey within **3 months (90 days)** of the approval date. **Failure to return the log will result in ineligibility for future grants.** You will receive a mailed approval letter, respite survey log, and grant payment. You will then have 3 months (90 days) to use the funds and return the Respite Survey Log.

a. **FOR THE REIMBURSEMENT GRANT; after approval you will receive a mailed approval letter and respite service log. You will have 3 months (90 days) to use the funds and return the respite service log to receive grant payment.** You may request payment to yourself as reimbursement or directly to the care provider. If you hire a care providing company, they may submit an invoice directly to Alzheimer's Arkansas for payment. Payment or reimbursement may take up to 15 business days to process and receive.

6.) KEY TERMS

Caregiver – Person completing this application who assists the care recipient with daily functions.

Care Recipient – The patient receiving care.

Care Provider – Person hired (to be paid) by the caregiver to provide care (CANNOT be the Caregiver).

Respite – A short period of rest or relief from caregiving duties.

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

KEEP THIS SHEET FOR YOUR RECORDS

GRIEVANCE POLICY

Alzheimer's Arkansas Programs and Services clients may file a grievance or seek resolution of a complaint or concern without fear of retaliation or discontinuation of service. Every client and/or caregiver can be assured that they will be treated with dignity and respect.

WHO MAY APPEAL: any person (or their caregiver) who is receiving or has applied for grants administered directly by Alzheimer's Arkansas Programs and Services.

WHAT YOU MAY APPEAL: decisions made within the grant administration services provided by Alzheimer's Arkansas Programs and Services with which you disagree.

WHERE TO SEND YOUR APPEAL OR GRIEVANCE:

Alzheimer's Arkansas Programs and Services
Grievance Review
201 Markham Center Drive OR Email: info@alzark.org
Little Rock, AR 72205

HOW TO APPEAL:

1. You are encouraged to discuss any concerns with the Alzheimer's Arkansas employee assigned to handling your initial request. You should request a conference with this employee before formal grievance procedures are initiated.
2. Should this meeting result in an adverse action or decision, you may request, in writing, reconsideration from the Executive Director. This request is to be made within 7 calendar days of the adverse decision.
3. Within 7 calendar days of receipt of your request, the Executive Director will schedule a reconsideration conference to hear your complaint. A decision concerning your reconsideration will be postmarked within 7 days of the conference.
4. If you are not satisfied with the Executive Director's decision, you have 7 calendar days to request, in writing, a formal hearing before the Executive Committee of the Board of Directors.
5. The Executive Committee will notify you within 7 calendar days of the date, time and place of the hearing. You may be present at the hearing, present evidence and witnesses and cross-examine adverse witnesses.
6. Within 7 calendar days of the hearing, the Executive Committee will mail its findings and decision.
7. If your grievance pertains to the CareLink grant, and you are dissatisfied with this decision, you may contact CareLink (Central Arkansas Area Agency on Aging) at 501-372-5300 or the Division of Provider Services and Quality Assurance (DPSQA) at the Department of Human Services at 501-682-2441.

NOTE: Upon written mutual agreement between client and Alzheimer's Arkansas staff, any or all steps of the Grievance Procedure may be omitted and/or time frames extended. If unable to read and/or write, or if you have a language barrier, Alzheimer's Arkansas will assist you in locating necessary assistance to complete the prescribed procedures.

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PLEASE COMPLETE EVERY FIELD

CAREGIVER Information (Primary Caregiver, unpaid person providing care to patient):

Legal Name:

DOB: **SSN:**

Gender: ☐ Female ☐ Male **Gender Identity:**

Physical Address:

City: **State:** **Zip:** **County:**

Mailing Address (if different from above):

Phone: **Email:**

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

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

Relationship to the patient:

Hours of care provided daily:

Employment Status: ☐ Employed ☐ Unemployed

How did you hear about this grant?

Received respite grant in past 12 months? ☐ Yes ☐ No

If so, from where?

CARE RECIPIENT Information (Patient, person receiving care):

Legal Name:

DOB: **Age:** **SSN:**

Gender: ☐ Female ☐ Male **Gender Identity:**

Physical Address:

City: **State:** **Zip:** **County:**

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

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

Patient Diagnosis:

Lives alone? ☐ Yes ☐ No **In Rural area?** ☐ Yes ☐ No

Primary Speaking Language:

Gross Monthly Household Income for Care Recipient:
$

Utilizing DHS Waiver or State Plan Service Programs (if any):
☐ Yes ☐ No

What kind of respite assistance are you applying for?

☐ **In-Home Care** ☐ **Adult Daycare** ☐ **Short-Term Facility Stay** ☐ **Family/Friend**

☐ **I UNDERSTAND THAT, IF APPROVED, GRANT FUNDS MUST BE USED WITHIN 90 DAYS**

NOTE: This application MUST be submitted with a diagnosis letter on doctor's letterhead of any chronic illness or any form of Dementia. The diagnosis must state the chronic illness, state that the patient requires daily assistance with (ADL) OR (IADL), be signed by the doctor or certified medical practitioner, and dated within a year of submitting the application.

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Pre-Funding Survey

Please answer the following questions. All comments are helpful and help us understand the needs of Arkansas caregivers. Your answers **do not** affect eligibility.

Please rate the financial burden that paying out-of-pocket for respite care places on your family:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **(Low → High)**
Please rate how easy it was to apply for this grant:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **(Easy → Hard)**
Please rate your current stress level:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **(Low → High)**
Prior to applying for this grant, had you ever received respite care services?	☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Alzheimer's Arkansas Programs and Services to obtain information about the care recipient/patient to receive respite care services. **Information may be obtained from:** Department of Human Services and/or CareLink.

PLEASE ACKNOWLEDGE EACH STATEMENT BY CHECKING THE BOXES BELOW

☐ My authorization remains effective from the date signed until one year after, handled confidentially in compliance with all federal laws.

☐ I may see the information to be sent and may revoke this authorization at any time.

☐ I have read and understand the nature of this release.

Signature of Patient / Patient's Designated Representative **Date**

Individuals, other than yourself, with whom grant information is shared with:

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:

PLEASE ACKNOWLEDGE EACH STATEMENT BY CHECKING THE BOXES BELOW

☐ My grant may be declined 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.

☐ Grant funds may only be used to hire a 3rd party provider to provide respite. These funds cannot be used to pay myself to provide care.

☐ Alzheimer's Arkansas Programs & Services is not liable for the quality of care, any negligence, or outstanding balances associated with the care provider of my choice.

☐ I have read the Application Process page and understand the terms and conditions of receiving this grant.

☐ Payment will not be made for services completed prior to my application approval date. I must submit proper records to receive payment or reimbursement.

☐ Payment is limited to fund availability. It may take up to 10 business days to process my application.

☐ I will complete and return the Respite Service Log and Survey upon completion of services. Failure to return it will make me ineligible for future grants.

Acceptance & Signature of Caregiver **Date**

Alzheimer's Arkansas does not discriminate on the basis of race, color, national origin, gender, sexual orientation, religion, age, or disability in employment, for granting, or for the provision of programs and services.

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