

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 specific illness, be signed by the doctor or certified care physician, 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. **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

The completed application, last page signed and dated, must be submitted with a diagnosis letter or prescription pad. (Diagnosis letters stay on file for one year.) Applications may be sent via mail, email, fax, or text. **It may take up to 10 business days to process your application.** After approval you will receive a mailed approval letter and grant payment. You will then have 3 months (90 days) to use the funds and return the Respite Survey Log.

4.) GRANT COVERAGE

This grant 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.

THIS GRANT DOES NOT PAY THE CAREGIVER TO PERFORM THEIR DAILY CAREGIVING DUTIES.

5.) GRANT COMPLIANCE

You **MUST** complete and return the Respite Survey Log within **3 months (90 days)** of the approval date. Failure to return the log will result in ineligibility for future grants.

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.

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CAREGIVER Information (unpaid person providing care to patient):

Legal Name:(First): (Middle): (Last):

DOB: __/__/____ Age: SSN:

Gender: ☐Male ☐Female Gender Identity:

Physical Address:

City: State: Zip: County:

Mailing Address (if different from above):

Phone: Email:

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 ☐ Am. Indian
☐ Asian ☐ Hispanic ☐ Other

Relationship to the patient:

Hours of care provided daily:

How did you hear about this grant?

Employment Status: ☐ Employed ☐ Unemployed

DHS Waiver or State Plan Service Programs (if any):

Gross Monthly Household Income: \$

CARE RECIPIENT Information (patient, person receiving care):

Legal Name:(First): (Middle): (Last):

DOB: __/__/____ Age: SSN:

Gender: ☐Male ☐Female Gender Identity:

Physical Address:

City: State: Zip: County:

Mailing Address (if different from above):

Phone: Email:

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 ☐ Am. Indian
☐ Asian ☐ Hispanic ☐ Other

Patient Diagnosis:

Live alone? ☐ Yes ☐ No Rural area? ☐ Yes ☐ No

Primary Speaking Language:

County Care Recipient Resides In:

DHS Waiver or State Plan Service Programs (if any):

Gross Monthly Household Income: \$

Live in rural area? ☐ Yes ☐ No Live alone? ☐ Yes ☐ No

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

If so, from where?

For what kind of assistance are you applying? Respite, indicate how.

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

Other assistance requested: _____

NOTE: This application MUST be submitted with a diagnosis letter on doctor's letterhead for Alzheimer's disease, any form of dementia or chronic illness. The diagnosis must state the specific disease or illness, confirm the patient requires daily assistance, be signed by the doctor or advanced practice provider, and be dated within a year of this application. Diagnosis letters may be emailed, faxed, mailed, or texted.

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 below:

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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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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 level of burden paying out-of-pocket for respite care:

☐ 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

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.

- ☐ 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 Representative

Date

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 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 Survey Log 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.