CAREGIVER SERVICES APPLICATION

Revised 7/24

Note: this application can be used to apply to either the National Family Caregiver Support Program and/or the CT Statewide Respite Care Program. Please complete the application and submit to your local Area Agency on Aging. Please do not leave any questions blank. PLEASE PRINT.

CARE RECIPIENT INFORMATION:

Care Recipient's Name: ______________________________

Marital Status: (Please check the one that applies to the care recipient)

☐Never married ☐ Married ☐Widowed ☐Separated ☐Divorced

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other **Veteran or dependent**: ☐ Yes ☐ No

Age: **Date of Birth:** ____/___/___ **Social Security Number: XXX-XX-**_____
MO/DAY/YR

Address, if different from the Caregiver:

____
Street City/CT/Zip

Telephone: ____(if different than Caregiver)

Type of Housing: (Please check the one that applies to the care recipient)

☐ Private home ☐ Board and care home ☐ Senior Housing ☐ Public housing
☐ Private apartment ☐ Nursing home/Institution ☐ Congregate housing
☐ Other: ____

Living Arrangement (Please check the one that applies to the care recipient)

☐ Alone ☐ With spouse ☐ With Unmarried Partner ☐ With spouse/partner & children ☐ With children only
☐ With Grandchildren ☐ With Other Relatives ☐ With Others
☐ If with "Other Relatives" or "Others" please describe: ____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Race: ☐ White, Non-Hispanic ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Black/African American ☐ White, Hispanic ☐ Other: __________________________

Primary Language Spoken at Home:

☐ American Sign Language	☐ Arabic	☐ Cambodian (Khmer)	☐ Chinese
☐ English	☐ French	☐ German	☐ Greek
☐ Gujarati	☐ Haitian Creole	☐ Italian	☐ Korean
☐ Polish	☐ Portuguese	☐ Russian	☐ Spanish
☐ Tactical Sign Language	☐ Turkish	☐ Urdu	☐ Vietnamese
☐ Other			

Speaks English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Disabled: ☐ Yes ____________________________ ☐ No

Primary Physician: ___________________________________ **Telephone:** _______________________

Medical Diagnosis:

____

____

Any Pets: ____ **Smoker:** ☐ Yes ☐ No

1. Does the care recipient currently receive **MEDICAID (TITLE 19)**? ☐ Yes ☐ No

   If No, is the care recipient currently applying for **MEDICAID (TITLE 19)**? ☐ Yes ☐ No

2. Does the care recipient currently receive services from the other respite programs?
   ☐ Yes ☐ No

   If no, is the care recipient currently applying for services from another respite program?
   ☐ Yes ☐ No

3. Does the care recipient currently receive services from the **CT Home Care Program for Elders**?
   ☐ Yes ☐ No

   If no, is the care recipient currently applying for the **CT Home Care Program for Elders**?
   ☐ Yes ☐ No

4. Does the care recipient require assistance with any of the following ADL activities? (please check)

   ☐Eating ☐Dressing ☐Bathing ☐Using the Toilet ☐Continence ☐Walking
   ☐Moving in and out or bed or chair

   Does the care recipient have need help with any of the following IADL activities? (please check)

   ☐Planning/Preparing Meals ☐Shopping ☐Managing Money ☐Using the Telephone
   ☐Housekeeping ☐Doing Laundry ☐Taking Medicine ☐Using Transportation

5. **Explain the reason(s) the *caregiver* is requesting services:**

6. **Explain the type of assistance needed:**

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7. **Does the care recipient receive any *additional* home or community-based services (such as a visiting nurse or going to an Adult Day Center)? If yes, please list the services:**

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8. **Note the name of any agency you are currently using or would like to use:**

____

____

____

FAMILY CAREGIVER INFORMATION

Caregiver's Name: ____

Marital Status: ☐ Never married ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other

Date of Birth: ____/___/___ MO/DAY/YR

Social Security Number: **XXX-XX-_______** (Last four digits only)

Address including PO Box's: ____
(Street and PO Box) City/ST/Zip

____

E-mail address: ____

Telephone – Home: ___________________ Work: ___________________ Cell**:** __________________

<u>Caregiver's Relationship to Care Recipient:</u>

☐ Brother	☐ Daughter	☐ Daughter-in-Law	☐ Domestic Partner
☐ Father	☐ Granddaughter	☐ Grandfather	☐ Grandmother
☐ Grandson	☐ Husband	☐ Mother	☐ Non-Relative
☐ Other Relative	☐ Sister	☐ Son	☐ Son-in-Law
☐ Wife			

☐ If "Non-Relative" or "Other Relative" please describe: _________________________________

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Race: ☐ White, Non-Hispanic ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Black/African American ☐ White, Hispanic ☐ Other: __________________________

Caregiver Primary Language Spoken at Home:

☐ American Sign Language	☐ Arabic	☐ Cambodian (Khmer)	☐ Chinese
☐ English	☐ French	☐ German	☐ Greek
☐ Gujarati	☐ Haitian Creole	☐ Italian	☐ Korean
☐ Polish	☐ Portuguese	☐ Russian	☐ Spanish
☐ Tactical Sign Language	☐ Turkish	☐ Urdu	☐ Vietnamese
☐ Other			

Speaks English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Income: ***Caregiver income** info is used to identify other sources of support and is not a determining factor of eligibility*

I live alone or with someone other than a spouse and MY monthly income is about:		
☐ At or Below $1,215 *(100%)*	☐ $1,216 - $1,519 *(125%)*	☐ $1,520 - $1,823 *(150%)*
☐ $1,824 - $2,126 *(175%)*	☐ $2,127 - $2,430 *(200%)*	☐ $2,431 or over *(over 200%)*
I live with my spouse and OUR monthly income is about:		
☐At or Below $1,643 *(100%)*	☐$1,644 - $2,054 *(125%)*	☐$2,055 - $2,465 *(150%)*
☐$2,466 - $2,876 *(175%)*	☐$2,877 - $3,287 *(200%)*	☐$3,288 or over *(over 200%)*

How did you hear about the Program? (Check all that apply)

☐ Newspaper ☐ From a Friend ☐ Area Agency on Aging ☐TV ☐ Radio

☐ Internet ☐ Other* (please describe) ____

*** If agency, please write the agency name and number of the person making the referral.**

Income / Asset Statement

(This information applies to both programs)

Please list care recipient's sources of income. The following are considered income: Social Security (minus Medicare Part B and Part D Premiums), Supplemental Security, Railroad Retirement Income, Pensions, Wages, Interest and Dividends, Net Rental Income, Veteran's Benefits, and any other payments received on a one-time recurring basis.

Please indicate liquid assets of the care recipient and his or her spouse. Liquid assets are defined as an asset that can be converted into cash within twenty working days. List account balances for all liquid assets, including checking accounts, certificates of deposit, savings accounts, individual retirement accounts, stocks, bonds, and all life insurance policies. Include all accounts solely held in the care recipient's name as well as any accounts jointly held with another person(s). If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

	Monthly Amount		
	Care Recipient	Spouse	
1. Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	$ ____________	____________ (*Optional)	
2. Pensions, retirement income, annuities	$____________	____________ (*Optional)	
3. Veteran's Benefits	$ ____________	____________ (*Optional)	
4. Interest and Dividends	$ ____________	________ (joint?)	__________ with whom?
5. Other income (wages, net rental income, non-taxable income)	$ ____________	________ (joint?)	__________ with whom?
TOTAL AMOUNT OF INCOME	$ ____________ (Care recipient)	________ (joint?)	__________ with whom?

*Spousal income information is used to identify other sources of support and is not a determining factor of eligibility.

Liquid Assets	**Amount**	**Joint?**	
______________________________________	$______________	______	_______ with whom?
______________________________________	$______________	______	_______ with whom?
______________________________________	$______________	______	_______ with whom?
______________________________________	$______________	______	_______ with whom?
TOTAL AMOUNT OF LIQUID ASSETS	$______________	______	_______ with whom?

CERTIFICATION AND AUTHORIZATION

(This information applies to both programs)

I certify that the information on this form is true, accurate, and complete.

I further authorize any health care provider to release any medical records to ensure that appropriate services are provided by the program.

____

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT DATE

If an individual is authorized to act as legal representative for the care recipient, please provide documentation of such power (e.g. power of attorney, appointment of conservatorship through Probate Court.)

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
FAX: 860-251-6107
WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

COST SHARE AGREEMENT

(For the National Family Caregiver Support Program only)

I am applying for services for: ____

Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I may be asked to make a cost share contribution for the cost of the services received. This determination is based upon a sliding fee scale and the individual's income as compared to the most recent US Poverty Guidelines (see attachment to this application for the scale). The Area Agency on Aging shall determine whether the participant qualifies to participate in cost-sharing for this program. The cost share shall be used to replenish program funds and therefore assist other caregiving families, and shall be made directly to North Central Area Agency on Aging (NCAAA).

____

Signature of Caregiver Date

I understand that if I have questions I can call:

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FAX: 860-251-6107
WEB: www.ncaaact.org
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CO-PAYMENT AGREEMENT

(For the Connecticut Statewide Respite Care Program only)

I am applying for services for: ____

Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I will be asked to make a co-payment for a portion of the cost of the services received.

The Statewide Respite Care Program requires that participants pay a 20% co-payment of the cost of the services received. This co-payment may be waived based upon demonstrated financial hardship and is determined by the Agency. I understand that if I have an emergency that makes me unable to pay my fee that I must contact the Area Agency as soon as possible, and a special payment schedule may be arranged.

I understand that the amount of my payment could change if the services I receive are modified. If this occurs, I understand that I will be notified.

The co-payment shall be used to replenish program funds and therefore assist other caregiving families. The co-payment shall be made directly to North Central Area Agency on Aging (NCAAA).

____

Signature of Caregiver Date

I understand that if I have questions I can call:

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*PHYSICIAN STATEMENT

(*A physician's statement must be obtained for care recipients under the age of 60 who have irreversible or deteriorating dementia or is seeking help only from the Connecticut Statewide Respite Care program.)

An application has been made to North Central Area Agency on Aging (NCAAA) for the individual named below. In order to evaluate the application, information is needed regarding the disability, health and medical problems, and the level of care of the individual. Please answer the following questions.

Patient's Name: ____

Date of Birth: ______________________

Address: ____

Phone: _____________________

For Physician use only:

Does this patient have irreversible and deteriorating dementia?

☐ **Yes** ☐ **No**

____

SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print): ____

Address: ____

____

Telephone: _____________________________

Please return form to:

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
FAX: 860-251-6107
WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

CAREGIVER OR AUTHORIZED AGENT: Please complete this page and send it, along with the physician's statement, to your physician.

I agree to the release of medical information on:

____
Name of Patient

____
Address

____
Phone

____
Date of Birth

____
SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT

____
DATE

Please return this form to:

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