CAREGIVER SUPPORT SERVICES APPLICATION

Please complete all elements of this application to be considered for caregiver support services. Once the application is completed and submitted, a representative from the Area Agency on Agency that serves your region will be in touch with you. You should be contacted within 5 business days. If you have any questions, please call 1-800-994-9422.

CAREGIVER'S Information

This is information about YOU as the Caregiver

Caregiver's Name: _____
(first) (last)

Today's date: _____ (XX/XX/XXXX)

Gender (of the caregiver): ☐ Male ☐ Female ☐ non-binary ☐ Other

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: ____/___/___ (MM/DD/YYYY)

Address of Caregiver: _____ *(Street or PO Box)*
_____ *(City/ST/Zip)*

Please indicate the BEST phone number to reach you: _____

Email address: _____

Caregiver's Relationship to Care Recipient *(Check all that apply)***:**
☐ Mother ☐ Father ☐ Husband/Wife ☐ Domestic Partner ☐ Brother ☐ Sister
☐ Daughter-in-Law ☐ Son-in-law ☐ Son ☐ Daughter ☐ Granddaughter ☐ Grandson
☐ Grandfather*☐ Grandmother* ☐ non-relative ☐ Conservator of Person**
☐ Conservator of Estate**☐ Health Care Representative** or Power of Attorney**
☐ Other _____

**Only check if the caregiver is age 55 or older and is the primary caregiver for a child under age 18 or an adult child between age 18 - 59 with a disability. Non-Relative and Other Relative may be checked for these caregivers as well as caregivers of older adult.*

***If you are authorized to act as legal representative for the care recipient, you will be asked to provide documentation of such authority.*

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Other_____

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

Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Unknown

Race: American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White–Not Hispanic/Latino ☐ White-Hispanic/Latino ☐ Other: _____

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

☐ Area Agency on Aging ☐ TV ☐ Radio ☐ Internet

☐ Agency Referral, if so, please indicate which one: _____

☐ Other_____

As a Caregiver, what do you find the most stressful aspect of your role? *(example: "Finding time for myself" or "Being able to go to my own appointments")***:**

_____

_____

As a Caregiver, what are some things you need assistance with to better fulfill your role? *(example: "I need help with grocery shopping")***:**

_____

_____

Please use this box for any additional information:

_____

_____

_____

_____

_____

_____

_____

CARE RECIPIENT'S Information

Care Recipient's Name: (the *"care recipient" is the person for whom you are providing care)*: _____
(first) (last)

Gender (of the care recipient): ☐ Male ☐ Female ☐ non-binary ☐ Other

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

Is the care recipient a Veteran or Dependent of a Veteran: ☐ Yes ☐ No

Date of Birth: ____/___/___ (MM/DD/YYYY)

Address of Care Recipient: _____ *(Street or PO Box)*
_____ *(City/ST/Zip)*

Please indicate the phone number of the Care Recipient: _____

Town of residence of the care recipient (if different than mailing address) This is used to ensure your application gets to the AAA that serves your region): _____

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Other _____

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

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Race: ☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White–Not Hispanic/Latino ☐ White-Hispanic/Latino ☐ Other: _____

Type of Housing: (*Please check the one that applies to the care recipient)*
☐ Private home ☐ Private apartment ☐ Senior housing ☐ Congregate housing ☐ Public housing ☐ Residential Care home ☐ Nursing home/Institution ☐ Assisted Living
☐ Other (Please specify): _____

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

☐ Alone ☐ With spouse only ☐ With spouse/partner & children ☐ With partner/unmarried ☐ With children, no spouse/partner ☐ With grandchildren ☐ With other relatives ☐ Other: _____

Has the Care Recipient been diagnosed with:

☐ Alzheimer's disease ☐ Early On-Set dementia ☐ Vascular Dementia ☐ Lewy Body Dementia ☐ Frontotemporal Dementia ☐ Mixed Dementia ☐ Parkinson's Disease with dementia ☐ None of the above ☐ I don't know

*(*For those whose care recipient has Alzheimer's or related dementia that is irreversible and deteriorating in nature, the attached physician's statement must be completed.)*

If there is a diagnosis, what stage?

☐ Mild ☐ Moderate ☐ Severe ☐ I don't know

Does the care recipient have a disability?

☐ Yes *(Please specify)* _____ ☐ No ☐ I don't know

Name of Primary Physician: _____

Telephone: _____

Medical Diagnoses (please list all):

_____

_____

Any Pets: ☐ Yes ☐ No If yes, what kind of pets? _____

Are there any smokers in the home: ☐ Yes ☐ No ☐ I don't know

<u>Other Supports</u>

1. Does the Care Recipient currently receive **MEDICAID (TITLE 19)**?
   ☐ Yes ☐ No ☐ I don't know

   If no, is the care recipient currently applying for **MEDICAID (TITLE 19)**?
   ☐ Yes ☐ No ☐ I don't know

2. Does the care recipient currently receive services from the **CT Home Care Program for Elders**? ☐ Yes ☐ No ☐ I don't know

   If no, is the care recipient currently applying for the **CT Home Care Program for Elders**? ☐ Yes ☐ No ☐ I don't know

3. Does the care recipient require assistance with any of the following **Activities of Daily Living** (ADLs)? *(please check all that apply)*

☐ Eating ☐ Bathing/Washing ☐ Dressing ☐ Toileting ☐ Walking

☐ Continence (Bladder/Bowel Control) ☐ Getting out of bed/chair

4. Does the care recipient receive any *additional* home or community-based services (such as a visiting nurse or going to an Adult Day Center)?

☐ Yes ☐ No ☐ I don't know

If yes, what types of services does the care recipient currently receive and from what agency: _____

_____

5. Does the Care Recipient have challenges with or need help with any of the following Instrumental **Activities of Daily** Living (IADLs)? (*Please check all that apply)* ☐ Planning/Preparing Meals ☐ Shopping ☐ Managing Money ☐ Using Telephone ☐ Housekeeping ☐ Doing Laundry ☐ Taking Medicine ☐ Using Transportation

CARE RECIPIENT'S Income / Asset Statement

Care Recipient's Income

Please list the care recipient's total sources of income, including the spouse's or other 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.

- Care Recipient's Monthly Income is: $ _____
- Care Recipient's Spousal Monthly Income: $ _____

Your Care Manager will use the incomes reported above to determine program eligibility.

Note: Spousal income information is used to identify other sources of support such as state funded benefits and is not a determining factor of eligibility.17a-860(c)(1)(A) Conn.Gen.Stat.

Care Recipient's Liquid Assets*

Please indicate liquid assets of the care recipient and his or her spouse. Assets owned with others may also be listed. Liquid assets are defined as an asset that

can be converted into cash within twenty (20) business 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 in the applicant's name as well as those in both the applicant's and their spouse's name. The house that the person resides in does not count as an asset.

- Care Recipient + Spouse is: $_____

**"Liquid assets" means any checking accounts, savings accounts, individual retirement accounts, certificates of deposits, stocks or bonds, that can be converted into cash within twenty working days. Include all accounts in the applicant's name as well as those in both the applicant's and their spouse's name.*

Are there any joint assets? (If you are unsure, your Care Manager may be able to help you to determine): ☐ Yes ☐ No ☐ I don't know

If so what and with whom? (example: care recipient owns a rental property with their sister) _____

CERTIFICATION AND AUTHORIZATION

I, _____, **certify that the information on this form is true, accurate, and complete to the best of my knowledge.**

_____

Signature Of Care Recipient/Authorized Representative or Responsible Person applying to the Caregiver Support Program on behalf of the Care Recipient.*

Today's date: _____(XX/XX/XXXX)

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

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

I, (name of care recipient) _____, agree to the release of medical information to the Area Agency on Aging for the purpose of determining my eligibility for the Caregiver Support Program.

_____
Name of Patient

_____
Address

_____
Phone

_____
Date of Birth (XX/XX/XXXX)

_____ _____
*Signature Of Care Recipient or Authorized Representative** *Today's Date*

_____
Please print Care Recipient Name clearly

*An authorized representative is an **adult**, over the age of **eighteen**, who has **written authorization** to act on the behalf of an assistance unit **of which he or she is not currently a member, and who would otherwise not be eligible to act without such authorization**.
Due to HIPPA, you may need to complete a separate authorization with the designated health care provider

Please return to:

NORTHCENTRAL
AREA AGENCY ON AGING

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

*PHYSICIAN STATEMENT

*(*Complete if care recipient has Alzheimer's or related dementia that is irreversible and deteriorating in nature, a physician's statement must be obtained.)*

Patient's Name: _____
Date of Birth: _____
Address: _____
Phone: _____

For Physician use only:

Has this patient been diagnosed with Alzheimer's or related dementia that is irreversible and deteriorating in nature?

☐ **Yes** ☐ **No**

☐ Alzheimer's disease ☐ Early On-Set Dementia ☐ Vascular Dementia ☐ Lewy Body Dementia

☐ Frontotemporal Dementia ☐ Mixed Dementia ☐ Parkinson's Disease with dementia

☐ N/A No diagnosis of Alzheimer's or Related Dementia

Date of original diagnosis: _____

If there is a diagnosis, what stage? ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

_____ _____
SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print): _____
Address: _____
_____
Telephone: _____

Please return to:

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Website: www.ncaaact.org

Connecticut Statewide Respite Care Program (CSRCP)

Caregiver Acknowledgment of Potential Co-Payment

Caregiver Name: _____
Care Recipient Name: _____
Date: _____

Purpose

The Connecticut Statewide Respite Care Program (CSRCP) provides up to $7500 per year in respite services. Depending on program eligibility criteria and income verification, a co-payment of 20% may be required to help offset the cost of services.

Acknowledgment

1. I understand that the **care recipient** may be responsible for a co-payment toward the total cost of respite services.
2. The 20% co-payment amount, if applicable, will be determined based on the care recipient's income and liquid assets as well as the program's established cost-sharing guidelines.
3. I understand that this co-payment must be made directly to the Area Agency on Aging provider, and that the respite services will not begin until the co-pay agreement has been signed.
4. I understand that failure to make the required co-payment may affect service delivery or eligibility for future funding through the program.
5. I will have the opportunity to ask questions and receive clarification regarding this policy when I meet with the assigned Care Manager at the AAA.

Caregiver Signature: **Date:**

Agency Use Only

Care Manager/AAA Representative Signature: Date:

☐ Co-payment required ☐ No co-payment required