Caregiver Support Programs Application Cover Sheet

Applicant Name: _____
Date: _____
This cover sheet accompanies the application for the Connecticut Statewide Respite Care Program (CSRCP) and the National Family Caregiver Support Program (NFCSP). These programs offer respite and supportive services to eligible caregivers or care recipients.

Program Eligibility:

CSRCP:

- ✓ The care recipient must have a formal diagnosis of Alzheimer's disease or a related dementia.
- ✓ The care recipient must meet financial eligibility requirements (income and asset limits apply).

NFCSP:

- ➢ The caregiver must be providing unpaid care to an individual 60 years or older OR to an individual with Alzheimer's disease or a related disorder (regardless of age).
- ➢ OR The caregiver is 60 years or older and providing unpaid care to an adult child with a disability.
- ➢ OR Grandparents or older relatives (age 55+) raising grandchildren may also be eligible for support services.

Checklist of Required Documents:
☐ Completed Application Form
☐ Proof of Diagnosis (if applicable) – A physician's note, medical record, or other official documentation confirming Alzheimer's or related dementia (required for CSRCP).
☐ Proof of Age (if required) – Copy of driver's license, birth certificate, or state ID.

Application Submission Instructions:

- ✓ Complete the enclosed application form.
- ✓ Attach the required documents listed above.
- ✓ Submit the completed application to:

Agency on Aging of South Central CT.
117 Washington Ave. Suite 17
North Haven, CT. 06473
Attention: Respite Department

Please Mail or Fax to 203-785-8873
If you need assistance completing the application, contact your local Area Agency on Aging at (203)785-8533 Option #4.

For more information on CSRCP and NFCSP, please visit:
https://portal.ct.gov/ads-caregivers

CAREGIVER SUPPORT SERVICES APPLICATION

Agency on Aging of South Central CT

Please complete all elements of this application to be considered for caregiver support services. Once the application is completed and submitted, a representative will be in touch with you. If you have any questions, please call 203-785-8533 Option # 4 and ask to speak with a staff member of the respite department.

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")*:

_____

_____

Caregiver monthly income: _____****

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:
Agency on Aging of South Central CT.
117 Washington Ave. Suite 17
North Haven, CT 06473
Phone: 203-785-8533
Fax: 203-785-8873

*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: _____