Western Connecticut Area Agency on Aging
Respite Service for Caregivers

Caregivers often find the task of caring for another person to be overwhelming. They often develop stress-related illnesses such as heart disease, hypertension, or ulcers. An occasional break from caregiving enables an exhausted caregiver to regroup both physically and emotionally, and find the strength to carry on. The Western Connecticut Area Agency on Aging offers the following types of services for caregivers through this application form:

RESPITE CARE: Respite care is a short term option designed to provide a break from the physical and emotional stress from caregiving. Respite care services include, but are not limited to: adult day care, home health aides, homemaker, companion, skilled nursing care, or short term assisted living or nursing home care. Funds may be used for day or night respite. Services are available through the funding of the federal **National Family Caregiver Support Program** or the **Connecticut Statewide Respite Care Program** funding.

SUPPLEMENTAL SERVICES: Supplemental services are one time health-related items or service options designed to help "fill the gap" when there is a need or there are no other ways to obtain the service or item. Supplemental services help improve the quality of life for the care recipient and help to alleviate the strain on caregivers who care for older individuals. Supplemental services include, but are not limited to, home safety modifications and medical related equipment. These services are available through the federal **National Family Caregivers Support Program** funding only.

The program selected for you will depend on meeting the eligibility requirements for the program and the types of services requested.

The term 'family caregiver' means an adult family member, or another individual who is an informal provider of in-home and community care. Only family caregivers who provide care to an individual with one or more of the following conditions are eligible to receive services under these programs. Services are funded through National Family Caregiver Support Program or the Connecticut Statewide Respite Care Program.

Please Note: If you are a grandparent or a relative caregiver for a child who is 18 years of age or younger, please complete: Connecticut's National Family Caregiver Support Program "Grandparent / Relative Caregiver Application"

PAYMENT FOR SERVICES & ELIGIBILITY:

The National Family Caregiver Support Program

The **National Family Caregiver Support Program** is funded by the Administration on Aging, and is operated in partnership with the State of Connecticut Department of Social Services and the Connecticut Area Agencies on Aging. **This is a donation based program and asks for a 20% contribution toward the cost of service.**

The person receiving care must:

1. Be 60+ years of age and is unable to perform at least two activities of daily living. Activities of daily living include bathing, dressing, toileting, eating, walking without substantial human assistance, including verbal reminding, physical cueing or supervision; OR
2. Be 60+ years of age and have a cognitive or other mental impairment that requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to him or herself or to another.

Priority will be given to:

1. Older individuals with the greatest social and economic need, with particular attention to low-income older adults; OR

2. Older individuals providing care and support to individuals with severe disabilities, including children with severe disabilities.

The Connecticut Statewide Respite Care Program

The **Connecticut Statewide Respite Care Program** is funded by the State of Connecticut Department of Social Services, and is operated in partnership with the Alzheimer's Association, Connecticut Chapter, and the Connecticut Area Agencies on Aging. **This program has a mandatory 20% co-payment toward the cost of services.** Due to financial hardship, a waiver request may be submitted.

The person receiving care must:

1. Have Alzheimer's disease or an irreversible dementia such as that which may result from: Multi infarct dementia, Parkinson's disease, Lewy Body Dementia, Huntington's disease, Normal Pressure Hydrocephalus, or Pick's disease. (The applicant or authorized agent must provide a completed "Physician Statement" from a physician stating that the patient has been diagnosed with one of the above.)
2. The person with one of these conditions must not have an income of more than $41,000 a year, or have liquid assets (in their name) of more than $109,000.

Direct payment to a caregiver other than a spouse or conservator may be allowed under specific circumstances and within limited guidelines through the Choices at Home pilot program.

Application Form

Please complete the following application. Please do not leave questions blank. Please Print.

Date of application: ____

Care Recipient Information (Applies to all programs)

Name of person receiving care: ____

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

Gender: ☐ Male ☐ Female **Veteran:** ☐ Yes ☐ No **Telephone:** (____) ______________

Age: ____ **Date of Birth:** ___/___/___ **Social Security Number:** XXX-XX - __ __ __ __
Mo / Day/ Yr

Residential Address:

____
Street City State Zip Code

Mailing Address (if different): **In care of:** ____

____
Street City State Zip Code

Care Recipient's Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Care Recipient's Race: (Please check all that apply)

☐ White, Non Hispanic ☐ White, Hispanic ☐ Black ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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

☐ Private Home ☐ Board or care home ☐ Senior Housing
☐ Private Apartment ☐ Public Housing ☐ Congregate Housing
☐ Other _____________________________________

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

☐ Alone ☐ With spouse / partner only ☐ With spouse & children
☐ With children only ☐ With other relatives ☐ With non-relatives

Primary Physician: ____
Telephone: (____) ___________________ Fax: (____) ___________________

Medical Diagnosis: ____
____
Allergies: _______________________________ **Pets:** _______________________________
Smoker: ☐ Yes ☐ No

Caregiver Information (Applies to all programs)

Caregiver's Name: ____

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

Gender:
☐ Male ☐ Female

Telephone: H: (____) ______________ C: (____) ______________W: (____) ______________

Age: ____ **Date of Birth:** ___/___/___
Mo / Day / Yr
Social Security Number: XXX-XX - __ __ __ __

Residential Address:

____
Street City State Zip Code

Mailing Address (if different):

____
Street City State Zip Code

Caregiver's Relationship to Care Recipient:

☐ Daughter
☐ Son
☐ Grandparent
☐ Daughter-in-Law
☐ Son-in-Law
☐ Other Relative
☐ Wife
☐ Husband
☐ Non-Relative

Caregiver's Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Caregiver's Race: (Please check all that apply)

☐ White, Non Hispanic ☐ White, Hispanic ☐ Black ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

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

☐ Private Home
☐ Private Apartment
☐ Other ____________________________________
☐ Board or care home
☐ Public Housing
☐ Senior Housing
☐ Congregate Housing

★*If an individual is authorized to act as legal representative for the care recipient, please provide documentation of such power (i.e.: power of attorney form, appointment of Conservatorship through Probate Court).*

How did you hear about our programs?

☐ Newspaper
☐Television
☐ From a Friend
☐ Radio
☐ Area Agency on Aging
☐ Internet
☐Other (please describe): ____
★ If this is an agency referral, please specify name of person making the referral along with the agency's name and number.

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 Connecticut Home Care Program for Elders?
   ☐ Yes ☐ No

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

3. Explain the need for this request for services.
   ____
   ____
   ____
   ____

4. Explain the type of assistance requested.
   ____
   ____
   ____
   ____

5. Does the care recipient receive any additional home or community based service? If yes, please list the services.
   ____
   ____
   ____
   ____

6. Note the name of any agency that is currently providing the care recipient with services, or that you would prefer to use.
   ____
   ____
   ____
   ____

Income / Asset Statement

This information applies to all 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, and bonds. Include all accounts in the applicant's name as well as those in both the applicant's and their spouse's name. If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

	Monthly Amount	
1. Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	$ ___________	
2. Pensions, retirement income, annuities	$___________	
3. Veteran's Benefits	$ ___________	
4. Interest and Dividends	$ ___________	______ (joint?)
5. Other income (wages, net rental income, non-taxable income)	$ ___________	______ (joint?)
TOTAL AMOUNT OF INCOME	$ ___________	

Does the spouse have income separate from the applicant? ☐ Yes ☐ No
If yes, approximate amount $_______________

Liquid Assets	**Amount**	**Joint?**
______________________________	$______________	____
______________________________	$______________	____
______________________________	$______________	____
______________________________	$______________	____
TOTAL AMOUNT OF LIQUID ASSETS	$______________	____

Does the spouse have assets separate from the applicant? ☐ Yes ☐ No
If yes, approximate amount $_______________

Office Use Only:
Individual: ☐ < $903 (100%) ☐ $904-$1,128 (125%) ☐ $1,129-$1,354 (150%) ☐ $1,355-$1,579 (175%)
☐ $1,580-$1,805 (200%) ☐$1,806 > (over 200%)

Couple: ☐ < $1,214 (100%) ☐ $1,215-$1,518 (125%) ☐ $1,519-$1,821 (150%) ☐ $1,822-$2,125 (175%)
☐ $2,126-$2,428 (200%) ☐$2,429 > (over 200%)

This information applies to all programs

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is true, accurate, and complete.
I further authorize any health care provider to release any or all medical records to ensure that appropriate services are provided by the program.

____

Signature of Caregiver   Date
Or Authorized Agent

CONTRIBUTION/CO-PAYMENT AGREEMENT

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 20% contribution or co-payment to help with the cost of the services received. The contribution or co-payment shall be used to replenish program funds and therefore assist other care-giving families. The contribution or co-payment shall be made directly to the Western Connecticut Area Agency on Aging.

____

Signature of Caregiver   Date

HOLD HARMLESS STATEMENT

By authorized signature below, I hold Western Connecticut Area Agency on Aging harmless from:

- any malpractice/other liability claims or legal actions resulting from action of sub-contractors acting as direct service providers;
- actions/omissions or other faults association with warranties/maintenance agreements of sub-contractors/providers, instructional use of equipment and/or equipment failure; OR
- care plan judgment made as a result of on-site assessments.

____

Signature of Caregiver   Date

Caregiver or Authorized Agent: This page is applicable only to those individuals applying for services who have a diagnosis of dementia.

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information on:

Name of Patient:

____

Address:

____

Street City State Zip Code

Telephone: (____) _______________ Date of Birth: ____/____/____

____

Signature of Caregiver or Authorized Agent Date

Caregiver or Authorized Agent: This page is applicable only to those individuals applying for services who have a diagnosis of dementia.

PHYSICIAN STATEMENT

An application has been made to the Western CT Area Agency on Aging 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: ______________________________________

Telephone: (____) ______________ **Date of Birth:** ____/____/____

Address:

____

Street City State Zip Code

Does this patient have dementia of the Alzheimer's type? Yes ___ No ___

Does this patient have an irreversible and deteriorating dementia? Yes ___ No ___

If yes, please list the cause of dementia. ____________________________

____

SIGNATURE OF PHYSICIAN DATE

Name of Physician (Please Print or Type): ___________________________

Address: ____

Telephone: (____) ______________ Fax: (____)______________

Please fax or return form to: WCAAA CT Statewide Alzheimer's Respite Care Program