

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

- Alone
- With Spouse only
- With Spouse & Children
- With Children only
- Other _____

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

- Never married
- Currently married
- Widowed
- Separated
- Divorced

Primary Physician: _____ Telephone: _____

Medical Diagnosis: _____

Any Pets: _____ Smoker: Yes No

How did you hear about the CT's National Family Caregiver Support 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

Please explain briefly below the reason that you are requesting respite and/ or supplemental services and include the type of assistance that you need as a caregiver. Please note the name of any agency you are currently using or would like to use.

Respite: _____

Supplemental: _____

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 Statewide Alzheimer's Respite Care Program? Yes No

If no, is the care recipient currently applying for the Statewide Alzheimer's Respite Care 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 receive any additional home or community based services? If yes, please list the services.

MONTHLY INCOME STATEMENT

Please check the total monthly income for the care recipient next to the appropriate income range. (Please refer to page 2 of this application for an explanation of what is considered to be income.)

Check the care recipient's appropriate monthly income:

- | | |
|---|---|
| <input type="checkbox"/> Under \$749 | <input type="checkbox"/> \$1,124 to \$1,310 |
| <input type="checkbox"/> \$749 to \$935 | <input type="checkbox"/> \$1,311 to \$1,497 |
| <input type="checkbox"/> \$936 to \$1,123 | <input type="checkbox"/> \$1,498 or over |

If the care recipient is married, check the spouse's monthly income:

- | | |
|---|---|
| <input type="checkbox"/> Under \$749 | <input type="checkbox"/> \$1,124 to \$1,310 |
| <input type="checkbox"/> \$749 to \$935 | <input type="checkbox"/> \$1,311 to \$1,497 |
| <input type="checkbox"/> \$936 to \$1,123 | <input type="checkbox"/> \$1,498 or over |

Certification

I certify that the information on this application is true, accurate and complete to the best of my knowledge or belief. I understand that if I provide false, fraudulent, or misleading information, I face fines and/or penalties under state and/or federal laws.

Signature of Caregiver or Authorized Agent

Date

Connecticut Family Caregiver Support Program
Respite and Supplemental Consumer Voluntary Contribution Agreement

I understand that (name of person receiving the care) _____
qualifies to receive the services indicated in this application. I understand that as the caregiver and as the person requesting respite and/or supplemental services, I am being asked to make a 20% contribution to help with the cost of the services received. The contribution shall be used to replenish program funds and therefore assist other caregiving families. The contribution shall be made directly to the Western Connecticut Area Agency on Aging.

I understand that if I have questions I can call the Western Connecticut Area Agency on Aging at 203-757-5449 or 1-800-994-9422.

Signature of Caregiver

Date

Hold Harmless Statement

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

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

I also understand that if I have questions I can call the Western Connecticut Area Agency on Aging at 203-757-5449 or 1-800-994-9422.

Signature of Caregiver

Date

Please send completed application including any documentation to:

Western Connecticut Area Agency on Aging
84 Progress Lane
Waterbury CT 06705