



Connecticut's National Family Caregiver Support Program Respite Care and Supplemental Services Application

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 Elderly Services Division and the Connecticut Area Agencies on Aging. Respite and Supplemental Services are offered through Connecticut's National Family Caregiver Support Program.

The Need for Respite and Supplemental Services:

Respite care is a SHORT-TERM option designed to provide a break from the physical and emotional stress of caregiving. By providing services to the individual being cared for, the caregiver has time to regroup from his/her caregiving responsibilities.

The program offers an opportunity for family caregivers to receive respite and/or supplemental services from approved community service providers. **The Care Recipient must be 60 years of age or older.** Respite care services include, but are not limited to: Assisted Living, Adult Day Care, Home Health Aide, Homemaker, Companion, Skilled Nursing Care or Short Term Nursing Home Care. Funds may be used for daytime or overnight respite. * **PLEASE NOTE: NOT ALL SERVICES ARE AVAILABLE IN EACH REGION.**

The Area Agency on Aging will arrange and pay for services; direct payment to a caregiver is prohibited. The Agency may request a contribution of 20% towards the cost of the respite service unless the care recipient's income is below federal poverty level. Please talk with the Area Agency on Aging Family Caregiver Program staff for more details.

Supplemental Services are one time health-related items, products, or services designed to help "fill the gap" when there is no other source of payment for the service or item. Supplemental services help improve the quality of life for the care recipient and help to alleviate the strain on their caregivers.

Supplemental services include, but are not limited to, home safety/modifications and medical related equipment. * **PLEASE NOTE: NOT ALL SERVICES ARE AVAILABLE IN EACH REGION.**

The Area Agency on Aging will arrange and pay for items or services; direct payment or reimbursement to a caregiver is prohibited. The Agency may request a contribution of 20% towards the cost of supplemental services unless the care recipient's income is below federal poverty level. Please talk with the Area Agency on Aging Family Caregiver Program staff for more details.

Eligibility to receive Respite and/or Supplemental Services

Definition: The term ‘family caregiver’ means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual aged 60 or older.

Only family caregivers who provide care to an older individual with at least one of the following two conditions are eligible to receive respite and/or supplemental services under this program:

The care recipient must:

1. Be unable to perform at least two activities of daily living. Activities of daily living include bathing, dressing, toileting, eating, and walking without substantial human assistance, including verbal reminding, physical cueing or supervision; or
2. 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 individual.

General priority guidelines:

Priority will be given to older individuals with greatest social and economic need, with particular attention to low-income older individuals and older individuals providing care and support to persons with mental retardation and related developmental disabilities (as defined in section in 42 USC 15002 (8)(A)). Please note that this program does not cover care recipients between the ages of 19-59.

Income:

Income is self-declared (**proof of income is not required**). Care recipients with incomes at or below federal poverty level are considered a priority for receiving services.

The following are considered income: Social Security, Supplemental Security, Railroad Retirement income; pensions; wages; interest; dividends; net rental income; veterans’ benefits; and any other payments received on a one-time or recurring basis. If accounts are jointly owned between a care recipient and another person such as the spouse, 50% of the total interest income in the account will be counted as care recipient income.

Please send completed application including any documentation to:
Western Connecticut Area Agency on Aging
84 Progress Lane
Waterbury CT 06705

If you have questions, please call 1-800-994-9422 or 203-757-5449 in the Waterbury area.

Connecticut's National Family Caregiver Support Program

Connecticut's National Family Caregiver Support Program Respite and/or Supplemental Services Application Form

Please complete the following application and do not leave any questions blank. PLEASE PRINT.

Date of application: _____

Care Recipient's Name: _____ Gender: Male Female
(The person who will receive the care who is age 60 or over.) Veteran: Yes No

Address:

Street _____ City _____ State _____ Zip _____

Telephone: _____

Age: ____ Date of Birth: ____/____/____ Social Security #: - ____ ____ ____ ____
Mo/Day/Yr (Last four digits only)

Care Recipient's Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Care Recipient's Race (please check all that apply) <input type="checkbox"/> Black <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian
---	---

Type of Housing where the Care Recipient lives:

- | | | |
|---|--|---|
| <input type="checkbox"/> Private home | <input type="checkbox"/> Board and care home | <input type="checkbox"/> Senior housing |
| <input type="checkbox"/> Public housing | <input type="checkbox"/> Private apartment | <input type="checkbox"/> Nursing home/Institution |
| <input type="checkbox"/> Congregate housing | <input type="checkbox"/> 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

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 (i.e. Adult Day Care, Home Health Aide, Homemaker).

MONTHLY INCOME STATEMENT (for the Care Recipient)

Please check the total monthly income 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 \$776 | <input type="checkbox"/> \$1,165 to \$1,358 |
| <input type="checkbox"/> \$776 to \$970 | <input type="checkbox"/> \$1,359 to \$1,552 |
| <input type="checkbox"/> \$971 to \$1,164 | <input type="checkbox"/> \$1,553 or over |

If the care recipient is married, check the combined monthly income:

- | | |
|---|---|
| <input type="checkbox"/> Under \$1,041 | <input type="checkbox"/> \$1,562 to \$1,821 |
| <input type="checkbox"/> \$1,041 to \$1,301 | <input type="checkbox"/> \$1,822 to \$2,082 |
| <input type="checkbox"/> \$1,302 to \$1,561 | <input type="checkbox"/> \$2,083 or over |

Caregiver's Name: _____ Gender: Male Female

Address: _____
Street City State Zip

Telephone: Home: _____ Work: _____ Cell: _____

e-mail: _____

Age: ____ Date of Birth: ____/____/____ Social Security #: - -____ ____ ____ ____
Mo/Day/Yr (Last four digits only)

Relationship to Care Recipient: Husband, Wife, Son/Son-in-Law, Daughter/Daughter-in-Law
 Other Relative Non-Relative

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 form, or appointment of conservatorship through Probate Court).

Caregiver's Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
--

Caregiver's Race (please check all that apply) <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
--

How did you hear about the 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 list the name, agency, and telephone 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: _____

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's Family Caregiver Support Program Respite and Supplemental Consumer Voluntary Contribution Agreement

I understand that (Name of Care Recipient) _____ 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 may be 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 Western Connecticut Area Agency on Aging will calculate the 20% of the amount paid for services and send a "Client Contribution Statement" to the caregiver requesting that amount.

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

Signature of Caregiver or Authorized Agent

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 Area Agency on Aging at 1-800-994-9422 or 203-757-5449.

Signature of Caregiver or Authorized Agent

Date

Please send completed application to:
Western Connecticut Area Agency on Aging
84 Progress Lane
Waterbury CT 06705