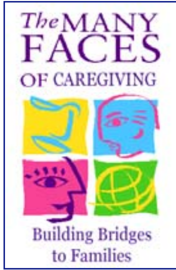

Connecticut's National Family Caregiver Support Program
Respite Care and Supplemental Services Application

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.

Please note: If you are a grandparent or relative caregiver for a child 18 years of age or younger, please complete the Family Caregiver Support Program "Grandparent/Relative Caregiver Application."*

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 (unless he/she is between the ages 19-59 with a disability, being cared for full-time by a relative caregiver who is not a parent.**) 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.

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.

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

*** PLEASE NOTE: NOT ALL SERVICES ARE AVAILABLE IN EACH REGION.**

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 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 care 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 himself 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 severe disabilities and those with Alzheimer's Disease and related disorders (as defined in the Older Americans Act, Section 372(b), (1)&(2).

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 the care recipient's 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 Care 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 #: X __X__X - X _X -___ ___ ___ ___
Mo-Day-Yr (Last four digits only)

Care Recipient's Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Care Recipient's Race (please check all that apply)
☐ Black
☐ Native American/Alaskan Native ☐ White
☐ Native Hawaiian or Other Pacific Islander ☐ Asian

Type of Housing where the Care Recipient lives:

☐ Private home ☐ Senior housing
☐ Public housing ☐ Private apartment
☐ 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 relative ___________________ ☐ 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 currently receive any additional home or community based services? If yes, please list the services (e.g., Adult Day Care, Home Health Aide, Homemaker) and the provider.
____
____
____

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:

☐ At or below $867	☐ $1,301 to $1,517
☐ $868 to $1,083	☐ $1,518 to $1,733
☐ $1,084 to $1,300	☐ $1,734 or over

If the care recipient is married, check the <u>combined</u> monthly income:

☐ At or below $1,167	☐ $1,751 to $2,042
☐ $1,168 to $1,458	☐ $2,043 to $2,333
☐ $1,459 to $1,750	☐ $2,334 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 #: X X X -X X -___ ___ ___ ___
Mo-Day-Yr (Last four digits only)

Relationship to Care Recipient: ☐ Husband ☐ Wife ☐ Son/Son-in-Law ☐ Daughter/Daughter-in-Law
☐ Brother ☐ Sister ☐ 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
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Caregiver's Race (please check all that apply)
☐ Black
☐ White
☐ Native American/Alaskan Native
☐ Asian
☐ 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 (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 Western Connecticut Area Agency on Aging will calculate the 20% and send a "Client Contribution Statement" showing the amount WCAAA paid for services and the suggested 20% contribution. Contributions are used to replenish program funds in order to assist other caregiving families.

I understand that if I have questions I can call the Western CT Area Agency on Aging toll-free at 1-800-994-9422, or in the Waterbury area at 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 associated 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 CT Area Agency on Aging at 1-800-994-9422, or in the Waterbury area at 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