CAREGIVER SERVICES APPLICATION

Revised 7/21

Note: this application can be used to apply to either the National Family Caregiver Support Program and/or the CT Statewide Respite Care Program. Please complete the application and submit to your local Area Agency on Aging. Different information is needed for each program and is noted at the top of each page.
Please do not leave any questions blank. PLEASE PRINT.

CARE RECIPIENT INFORMATION:

Care Recipient's Name: _____

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

☐Never married ☐ Married ☐Widowed ☐Separated ☐Divorced

Gender: ☐ Male ☐ Female **Veteran or dependent**: ☐ Yes ☐ No

Age: **Date of Birth:** ____/___/___ **Social Security Number: XXX-XX**-_____
MO/DAY/YR

Address, if different from the Caregiver:

_____
Street City/CT/Zip

Telephone: _____(if different than Caregiver)

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

☐ Alone ☐ With spouse only ☐ With spouse & children ☐ With children only
☐ Other: _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

Race: ☐ Non-Minority/White ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Black/African American ☐ Hispanic/white ☐ Other: _____

Disabled: ☐ Yes _____ ☐ No

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 other respite programs?
   ☐ Yes ☐ No

   If no, is the care recipient currently applying for services from another respite 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 require assistance with any of the following activities? (please check)

☐Eating ☐Bathing ☐Dressing ☐Using the Bathroom ☐Walking ☐Moving in and out or bed or chair

5. **Explain the reason(s) the *caregiver* is requesting services: _____**

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6. **Explain the type of assistance needed:**

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7. **Does the care recipient receive any *additional* home or community based services (such as a visiting nurse or going to an Adult Day Center)? If yes, please list the services:**

_____

8. **Note the name of any agency you are currently using or would like to use:** _____

FAMILY CAREGIVER INFORMATION

Caregiver's Name: _____ **Gender**: □ Male □ Female

Marital Status: □ Never married □ Married □ Widowed □ Separated □ Divorced

Date of Birth: ____/___/___ **Social Security Number:** **XXX-XX-_____**
MO/DAY/YR (Last four digits only)

Address including PO Box's: _____
(Street and PO Box) City/ST/Zip

_____

E-mail address: _____

Telephone – Home: _____ **Work:** _____ **Cell:** _____

Caregiver's Relationship to Care Recipient:

□ Daughter □ Daughter-in-law □ Wife □ Husband □ Son □ Son-in-law
□ Grandparent □ Non-Relative □ Other Relative: _____

Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown

Race: ☐ Non-Minority/White ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander
☐ Asian ☐ Black/African American ☐ Hispanic/white ☐ Other: _____

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, appointment of conservatorship through Probate Court.)

How did you hear about the 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 person making referral.**

Income / Asset Statement

(This information applies to both 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, 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. If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

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

*Spousal income information is used to identify other sources of support and is not a determining factor of eligibility.

Liquid Assets	**Amount**	**Joint?**	
_____	$_____	_____	_____ with whom?
_____	$_____	_____	_____ with whom?
_____	$_____	_____	_____ with whom?
_____	$_____	_____	_____ with whom?
TOTAL AMOUNT OF LIQUID ASSETS	$_____	_____	_____ with whom?

CERTIFICATION AND AUTHORIZATION

(This information applies to both programs)

I certify that the information on this form is true, accurate, and complete.

I further authorize any health care provider to release any medical records to ensure that appropriate services are provided by the program.

_____

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT DATE

COST SHARE AGREEMENT

(For the National Family Caregiver Support Program only)

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 cost share contribution for the cost of the services received. This determination is based upon a sliding fee scale and the individual's income as compared to the most recent US Poverty Guidelines (see attachment to this application for the scale). The Area Agency on Aging shall determine whether the participant qualifies to participate in cost-sharing for this program. The cost share shall be used to replenish program funds and therefore assist other caregiving families, and shall be made directly to North Central Area Agency on Aging (NCAAA).

_____

Signature of Caregiver Date

I understand that if I have questions I can call:

NORTHCENTRAL
AREA AGENCY ON AGING

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
FAX: 860-251-6107
WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

CO-PAYMENT AGREEMENT

(For the Connecticut Statewide Respite Care Program only)

I am applying for services for: _____

Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I will be asked to make a co-payment for a portion of the cost of the services received.

The Statewide Respite Care Program requires that participants pay a 20% co-payment of the cost of the services received. This co-payment may be waived based upon demonstrated financial hardship and is determined by the Agency. I understand that if I have an emergency that makes me unable to pay my fee that I must contact the Area Agency as soon as possible, and a special payment schedule may be arranged.

I understand that the amount of my payment could change if the services I receive are modified. If this occurs, I understand that I will be notified.

The co-payment shall be used to replenish program funds and therefore assist other caregiving families. The co-payment shall be made directly to North Central Area Agency on Aging (NCAAA).

_____

Signature of Caregiver Date

I understand that if I have questions I can call:

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AREA AGENCY ON AGING

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151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
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*PHYSICIAN STATEMENT

(*A physician's statement must be obtained for care recipients under the age of 60 who have irreversible or deteriorating dementia or is seeking help only from the Connecticut Statewide Respite Care program.)

An application has been made to North Central Area Agency on Aging (NCAAA) 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: _____

Date of Birth: _____

Address: _____

Phone: _____

For Physician use only:

Does this patient have irreversible and deteriorating dementia?

☐ **Yes** ☐ **No**

_____

SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print): _____

Address: _____

_____

Telephone: _____

Please return form to:

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
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EMAIL: info@ncaaact.org

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

CAREGIVER OR AUTHORIZED AGENT: Please complete this page and send it, along with the physician's statement, to your physician.

I agree to the release of medical information on:

_____

Name of Patient

_____

Address

_____

Phone

_____

Date of Birth

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT

_____

DATE

Please return this form to:

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