Western CT Area Agency on Aging, Inc.
84 Progress Lane, Waterbury, CT 06705
Phone: 203-757-5449 Fax: 203-757-4081

Services 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 State of Connecticut 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 **National Family Caregiver Support Program** or the **Connecticut Statewide Respite Care Program.** A mandatory assessment must be completed before respite services are provided.

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 **National Family Caregiver Support Program** only.

PROGRAM DESCRIPTION: Programs to assist caregivers are described on page two. The program selected for you will depend on available funding, meeting the eligibility requirements, and available services.

The term 'caregiver' means an adult relative or non- relative, or another individual who is an informal provider of in-home and community care. Only caregivers who provide care to the applicant that meets the eligibility requirements listed on the following page may receive services under these programs. **All applicants must have an identified caregiver in order to receive services.** Services are funded through National Family Caregiver Support Program or the Connecticut Statewide Respite Care Program.

Please keep program descriptions on pages one and two for your records.

The National Family Caregiver Support Program

The **National Family Caregiver Support Program** (NFCSP) is funded by the Administration For Community Living , and is operated in partnership with the State of Connecticut Department on Aging and the Connecticut Area Agencies on Aging. **This program requests a cost share contribution toward the cost of services received based on the care recipient's monthly income as listed below, donations are accepted for care recipients under 100% of the poverty level:**

Based on 2017 US Poverty Guidelines Income Range (% of FPL)	Individual 's Monthly Income	Cost Share Amount
0-100%	$0 to $1,012	donations accepted
150%	$1,013 to $1,518	5%
200%	$1,519 to $2,023	10%
250%	$2,024 to $2,529	20%
300%	$2,530 to $3,035	40%
350%	$3,036 to $3,541	60%
400%	$3,542 to $4,047	80%
Over 400%	$4,048 and over	100%

To be eligible, the **CAREGIVER** must:

- be over 18 and caring for a person aged 60 years or older, OR
- be a relative caregiver age 55 or older, who is not a parent, and is caring full-time for an adult age 19-59 with disabilities.

To be eligible, the **CARE RECIPIENT** must:

- need assistance with at least two activities of daily living (ADLs). ADLs include bathing, dressing, toileting, eating, walking without substantial human assistance, OR
- have a cognitive or other mental impairment that requires substantial supervision.

Priority will be given to older individuals with the greatest social and economic need, with particular attention to low-income older adults; or older individuals providing full-time care and support to adults with severe disabilities.

The Connecticut Statewide Respite Care Program

The **Connecticut Statewide Respite Care Program** (CSRCP) is funded by the State of Connecticut Department on Aging, 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.

To be eligible, 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 dementia.)
2. The person with the diagnosis must not have an income of more than **$45,620** a year or have liquid assets of more than **$ 121,283.**

Two options of care are available for CSRCP and NFCSP:

1. **Traditional Respite Services** – A Care Manager will order and monitor services through a licensed service provider such as a skilled or non-skilled service agency.

2. **Self- Directed Care** – The caregiver will select, hire, and supervise individuals other than a spouse or conservator to provide respite care. This option provides more flexibility in the selection and delivery of respite services.

APPLICATION FORM

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

CARE RECIPIENT INFORMATION:

Care Recipient's Name: ____ **Date:** __________________

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:** _______-______-_______
MO/DAY/YR

Address, if different from the Caregiver:

____
Street City/CT/Zip

Telephone – Home: _______________________ **Cell:** _______________________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 that the *caregiver* is requesting services:** ________________________________

____

____

6. **Explain the type of assistance that is needed*:*** ____

____

____

____

7. **Does the care recipient receive any *additional* home or community based services? 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 <u>documentation</u> 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 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, 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	$ ____________	___________	
2. Pensions, retirement income, annuities	$ ____________	___________	
3. Veteran's Benefits	$ ____________	___________	
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?

Does the spouse have assets separate from the applicant? If yes approximate amount ___________________

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 medical records to ensure that appropriate services are provided by the program.

____
SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT DATE

HOLD HARMLESS STATEMENT

By authorized signature below, I hold 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.

____
SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT DATE

COST SHARE AGREEMENT
FOR NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

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 page 2 of the application for the scale). The Agency 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 Western CT Area Agency on Aging.

____

Signature of Caregiver or authorized agent Date

I understand that if I have questions I can call: WCAAA @ (203) 757-5449

Please return application to: WCAAA, 84 Progress Lane
Waterbury, CT 06705
Phone: (203) 757-5449
Fax: (203) 757-4081

CO-PAYMENT AGREEMENT
FOR CONNECTICUT STATEWIDE RESPITE CARE PROGRAM

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 Western CT Area Agency on Aging.

____

Signature of Caregiver or authorized agent   Date

I understand that if I have questions I can call: WCAAA @ (203) 757-5449

Please return application to: WCAAA, 84 Progress Lane
Waterbury, CT 06705
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PHYSICIAN STATEMENT
FOR CONNECTICUT STATEWIDE RESPITE CARE PROGRAM

An application has been made to 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: ____

Date of Birth: ______________________________

Address: ____

Phone: ______________________________

Does this patient have irreversible and deteriorating dementia?

☐ **Yes** ☐ **No**

If yes, please list the type of dementia ____

____

SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print or Type): ____

Address: ____

Telephone: ______________________________________

Please return application to: WCAAA, 84 Progress Lane
Waterbury, CT 06705
Phone: (203) 757-5449
Fax: (203) 757-4081

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information on:

____
Name of Patient

____
Address

____
Phone

____
Date of Birth

____
SIGNATURE OF CLIENT, CAREGIVER OR AUTHORIZED AGENT

____
DATE

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

Please return application to: WCAAA, 84 Progress Lane
Waterbury, CT 06705
Phone: (203) 757-5449
Fax: (203) 757-4081

National Family Caregiver Support Program
Functional Status Evaluation Form

Date: ______________________

Name of Person Receiving Care: ____

Name of Caregiver: ____

How is the person receiving care able to function now? Please indicate with an "x" or "checkmark" the level of assistance needed in the following areas, and also the person who provides the assistance.

	Independent	Supervision only	Physical Assistance	Performed by others	Who?
Bathing					
Dressing					
Using Bathroom					
Taking Medications					
Eating					
Fixing Meals					
Housework					
Using the phone					

1. Based on available funds for this coming grant year, what assistance would be most helpful to you? Please describe respite care and/or supplemental services needed by the care recipient and, *in particular, how these services will be a support to the family caregiver*:

____
____
____
____

2. Please describe any changes in the status of the person receiving the care – for example, changes in medical or physical condition, financial situation, housing, etc.____
____
____
____

3. Please describe any changes in the family caregiver's circumstances – (changes in the caregiver's stress level, medical condition, financial situation, etc.): ____
____
____
____

4. Please tell us if the care recipient has applied for, or is currently receiving any services other than those funded by the National Family Caregiver Support Program:

____ Medicaid (Title 19)
____ CT Statewide Respite Care Program
____Meals on Wheels
_____ CT Home Care Program for Elders (CCCI)
_____ Alzheimer's Association grants
____ Other (please describe): ____