Services for Caregivers

Eligibility Requirements

Caregivers often find the task of caring for another person to be overwhelming. The challenges of caregiving can even lead to development of stress-related illnesses. An occasional break from caregiving can enable a weary caregiver to regroup both physically and emotionally. Both the National Family Caregiver Support Program and the Connecticut Statewide Respite Care Program are designed to assist you in your caregiving journey.

Who are “caregivers”? 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 care-recipient, and who meet the eligibility requirements listed on the following pages, may receive services under these programs. To be eligible for assistance a caregiver must meet specific requirements for program participation as stated in state regulations. Care recipients (person requiring care) must have an identified caregiver in order to receive services.

RESPITE CARE: Respite care is a short term option designed to provide a break from the physical and emotional stress of caregiving. Respite care services include, but are not limited to: adult day care, home health aides, homemakers, companions, 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 (NFCSP) or the Connecticut Statewide Respite Care Program (CSRCP). An assessment from a Case Manager is required before respite services are provided.

SUPPLEMENTAL SERVICES: Supplemental services are for purchasing items or services, mostly health-related, when there is a justified need and no other way to obtain the service or item. Supplemental services help improve quality of life for the care recipient and therefore alleviate strain on the caregiver. These services are available through the National Family Caregiver Support Program only and are determined in collaboration with the Case Manager.

PROGRAM DESCRIPTION: Programs to assist caregivers are described on the next two pages. The best program for you will depend on your fit with the eligibility requirements. Both programs are contingent upon available funding, and available services. All care recipients must have an identified caregiver in order to receive services.
The National Family Caregiver Support Program

The National Family Caregiver Support Program (NFCSP) is funded by the federal Administration for Community Living, and is operated in partnership with the State of Connecticut Unit 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:

<table>
<thead>
<tr>
<th>Percentage of Federal Poverty Level</th>
<th>Individual ‘s Monthly Income</th>
<th>Cost Share Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100%</td>
<td>0 to $1,041</td>
<td>donations accepted</td>
</tr>
<tr>
<td>150%</td>
<td>$1,042-$1,562</td>
<td>5%</td>
</tr>
<tr>
<td>200%</td>
<td>$1,562-$2,082</td>
<td>10%</td>
</tr>
<tr>
<td>250%</td>
<td>$2,083-$2,603</td>
<td>20%</td>
</tr>
<tr>
<td>300%</td>
<td>$2,603-$3,123</td>
<td>40%</td>
</tr>
<tr>
<td>350%</td>
<td>$3,124-$3,644</td>
<td>60%</td>
</tr>
<tr>
<td>400%</td>
<td>$3,644-$4,164</td>
<td>80%</td>
</tr>
<tr>
<td>Over 400%</td>
<td>$4,165+</td>
<td>100%</td>
</tr>
</tbody>
</table>

To be eligible, the CAREGIVER must:
- be age 18 or over and caring for a person aged 60 years or older, OR
- as in the case of a child, be an older relative caregiver, age 55 or older, who is the grandparent, step grandparent, or other relative, caring full-time for a child age up to age 18, OR
- be an older relative caregiver (including a parent) age 55 and over, caring for an adult child age 18-59 with disabilities.

To be eligible, the CARE RECIPIENT must:
- be at risk for institutional placement which means, with respect to an older individual, that individual is unable to perform at least 2 activities of daily living tasks without substantial assistance (including verbal reminding, physical cueing, or supervision). ADLs include bathing, dressing, toileting, eating, walking without human assistance, OR
- have a cognitive or other mental impairment that requires substantial supervision, OR
- person who has Alzheimer’s or a related condition regardless of age, OR
- an adult child age 18-59 with disabilities, OR
- a child under age 18 in the care of a relative caregiver (not a parent).

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. As these levels are subject to change each year, please check with your local Area Agency on Aging for updated figures.

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 (cannot be a spouse or conservator) to provide respite care. This option provides more flexibility in the selection and delivery of respite services.

Please keep these pages for your records.
CAREGIVER SERVICES APPLICATION

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-____

Address, if different from the Caregiver:

Street _____________________________ City/CT/Zip _____________________________

Telephone: ________________________________________________________________

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: ____________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
6. Explain the type of assistance needed:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Monthly Amount</th>
<th>Care Recipient</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social Security (minus Medicare Premiums), SSI, and Railroad Retirement</td>
<td>$ ___________</td>
<td>(*Optional)</td>
</tr>
<tr>
<td>2. Pensions, retirement income, annuities</td>
<td>$ ___________</td>
<td>(*Optional)</td>
</tr>
<tr>
<td>3. Veteran’s Benefits</td>
<td>$ ___________</td>
<td>(*Optional)</td>
</tr>
<tr>
<td>4. Interest and Dividends</td>
<td>$ ___________</td>
<td>(joint?) with whom?</td>
</tr>
<tr>
<td>5. Other income (wages, net rental income, non-taxable income)</td>
<td>$ ___________</td>
<td>(joint?) with whom?</td>
</tr>
</tbody>
</table>

**TOTAL AMOUNT OF INCOME**

$ ___________  (Care recipien)  (joint?) with whom?

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

<table>
<thead>
<tr>
<th>Liquid Assets</th>
<th>Amount</th>
<th>Joint?</th>
<th>with whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
<td>$ ___________</td>
<td>______</td>
<td>with whom?</td>
</tr>
<tr>
<td>__________________________</td>
<td>$ ___________</td>
<td>______</td>
<td>with whom?</td>
</tr>
<tr>
<td>__________________________</td>
<td>$ ___________</td>
<td>______</td>
<td>with whom?</td>
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<tr>
<td>__________________________</td>
<td>$ ___________</td>
<td>______</td>
<td>with whom?</td>
</tr>
<tr>
<td>__________________________</td>
<td>$ ___________</td>
<td>______</td>
<td>with whom?</td>
</tr>
</tbody>
</table>

**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

HOLD HARMLESS STATEMENT
(This information applies to both programs)

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 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 (AGENCY).

_______________________________________  ______________________________________
Signature of Caregiver                      Date

I understand that if I have questions I can call:
Western CT Area Agency on Aging
84 Progress Lane 2nd Floor
Waterbury, CT 06705
Phone: 203-757-5449
Fax: 203-757-4081
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 (AGENCY)

________________________________________  ________________________________________________
Signature of Caregiver                              Date

I understand that if I have questions I can call:
    Western CT Area Agency on Aging
    84 Progress Lane 2nd Floor
    Waterbury, CT 06705
    Phone: 203-757-5449
    Fax: 203-757-4081
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 (AGENCY) 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:

Western CT Area Agency on Aging
84 Progress Lane 2nd Floor
Waterbury, CT 06705
Phone: 203-757-5449
Fax: 203-757-4081
Attn: Jessica Warner
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:
Western CT Area Agency on Aging
84 Progress Lane 2nd Floor
Waterbury, CT 06705
Phone: 203-757-5449
Fax: 203-757-4081