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

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:**

Percentage of Federal Poverty Level	Individual 's Monthly Income	Cost Share Amount
0-100%	0 to $1,133	donations accepted
150%	$1,134-$1,699	5%
200%	$1,700-2,265	10%
250%	$2,266-$2,831	20%
300%	$2,832-$3,398	40%
350%	$3,399-$3,964	60%
400%	$3,965-$4,530	80%
Over 400%	$4,531+	100%

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 **$51,114** a year or have liquid assets of more than **$ 135,892.** 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**-_____
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: _____**

_____

_____

_____

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.

	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

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 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 Western CT Area Agency on Aging.

_____

Signature of Caregiver or authorized agency Date

I understand that if I have questions I can call: Western CT Area Agency on Aging @ 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 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 Western CT Area Agency on Aging

_____

Signature of Caregiver or authorized agent Date

I understand that if I have questions I can call: Western CT Area Agency on Aging @ 203-757-5449

Please return application to: WCAAA, 84 Progress Lane
Waterbury, CT 06705
Phone: (203) 757-5449
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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 are seeking help only from the 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: _____

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:

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

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 CLIENT, CAREGIVER OR AUTHORIZED AGENT

_____

DATE

Please return this form to:

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

CONNECTICUT STATE UNIT ON AGING

CAREGIVER PROGRAM APPLICATION ADDITIONAL PAGE

for use when receiving CSRCP/NFCSP applications created prior to revised version Winter 2021

To Consumer/Caregiver/Care Recipient: Since you last completed an application for services, the form has been updated to include some supplemental and more descriptive questions. Nothing has changed regarding eligibility for the programs, but we are collecting more information to get a better picture of the people we are serving across the state through these Caregiver Programs.

Please complete the following questions regarding the person who is in need of/being provided care (the Care Recipient):

Gender: ☐Female ☐Male ☐Non-Binary ☐Other

Primary Language Spoken at Home:

☐ American Sign Language	☐ Arabic	☐ Cambodian (Khmer)	☐ Chinese
☐ English	☐ French	☐ German	☐ Greek
☐ Gujarati	☐ Haitian Creole	☐ Italian	☐ Korean
☐ Tactical Sign Language	☐ Turkish	☐ Urdu	☐ Vietnamese

☐ Other _____

Speaks English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (check all that apply):

☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American

☐ Native Hawaiian/Pacific Islander ☐ White

Living Arrangement: (Please check the one that applies to the Care Recipient)

☐ Alone ☐ With spouse ☐ With Unmarried Partner ☐ With Spouse/Partner & Child/ren

☐ With Child/ren Only, No Spouse/Partner ☐ With Grandchildren ☐ With Other Relatives

☐ With Others *If with "Other Relatives" or "Others" please describe: _____

4. Does the **Care Recipient** have challenges/need help with any of the following ADL activities?

(please check all that apply if yes)

☐Walking	☐Eating	☐Dressing	☐Bathing/Washing
	☐Using the Toilet	☐Getting Out of Bed/Chair	☐Continence

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CONNECTICUT STATE UNIT ON AGING

CAREGIVER PROGRAM APPLICATION ADDITIONAL PAGE

for use when receiving CSRCP/NFCSP applications created prior to revised version Winter 2021

Does the **Care Recipient** have challenges/need help with any of the following IADL activities?

(please check all that apply if yes)

☐Planning/Preparing Meals ☐Shopping ☐Managing Money

☐Using the Telephone ☐Housekeeping ☐Doing Laundry

☐Taking Medicine ☐Using Transportation

And now some information regarding the Caregiver is needed:

Caregiver's Relationship to Care Recipient:

☐ Brother ☐ Daughter ☐ Daughter-in-Law ☐ Domestic Partner

☐ Father ☐ Granddaughter ☐ Grandfather ☐ Grandmother

☐ Grandson ☐ Husband ☐ Mother ☐ Non-Relative

☐ Other Relative ☐ Sister ☐ Son ☐ Son-in-Law

If "Non-Relative" or "Other Relative", please identify relationship:

_____

Caregiver Primary Language Spoken at Home:

☐ American Sign Language ☐ Arabic ☐ Cambodian (Khmer) ☐ Chinese

☐ English ☐ French ☐ German ☐ Greek

☐ Gujarati ☐ Haitian Creole ☐ Italian ☐ Korean

☐ Tactical Sign Language ☐ Turkish ☐ Urdu ☐ Vietnamese

☐ Other _____

Speaks English: ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race (check all that apply): ☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Income: **Caregiver income info is used to identify other sources of support and is not a determining factor of eligibility*

I live alone or with someone other than a spouse and **MY** income is:

At or Below $1,703 monthly or $12,880 annually ☐ Yes ☐ No

If No, **MY** income is At or Below $1,610 monthly or $19,320 annually ☐ Yes ☐ No

I live with my spouse and **OUR** income is:

At or Below $1,452 monthly or $17,420 annually: ☐ Yes ☐ No

If No, **OUR** income is At or Below $2,178 monthly or $26,130 annually ☐ Yes ☐ No