CAREGIVER SERVICES APPLICATION

Note: this application may be used to apply for the Caregiver Support Programs. Please complete the application and submit to your local Area Agency on Aging. The Area Agency on Aging staff will determine what program you qualify for.
Please do not leave any questions blank. PLEASE PRINT.

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 ☐ Non-Binary ☐ Other **Veteran or dependent**: ☐ Yes ☐ No

Age: _____ **Date of Birth:** ____/___/___
MO/DAY/YR

Address, if different from the Caregiver:

____

Street City/CT/Zip

Telephone: ____(if different than Caregiver)

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Other ______________________

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

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: _________________________

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 unmarried partner ☐ With spouse/partner & children
☐ With children, no spouse/partner ☐ With grandchildren ☐ With other relative ☐ Other _____________

Does the care recipient have a disability? ☐ Yes ____________________________ ☐ No

Primary Physician: ___________________________________ **Telephone:** _______________________

Medical Diagnoses (please list all):

____

____

Any Pets: ☐ Yes ☐ No What kind of 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 **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

3. Does the care recipient require assistance with any of the following activities? (please check)

☐Eating ☐Bathing ☐Dressing ☐Toileting ☐Walking ☐Getting out of bed/chair ☐ Continence

6. **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.**

____

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

____

8. **Does the Care Recipient have challenges/need help with any of the following activities?** (Please check all that apply if yes

☐Planning/Preparing Meals ☐Shopping ☐Managing Money ☐Using Telephone ☐Housekeeping
☐Doing Laundry ☐Taking Medicine ☐Using Transportation

__FAMILY CAREGIVER INFORMATION__

Caregiver's Name: ______________________________ Email address: __________________________

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

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

Date of Birth: ____/___/___

Mailing Address including PO Boxes:

____

(Street and PO Box) City/ST/Zip

____

Telephone – Home: ___________________ **Work:** ___________________ **Cell:** __________________

__Caregiver's Relationship to Care Recipient:__

☐ Daughter ☐ Daughter-in-law ☐ Wife ☐ Husband ☐ Son ☐ Son-in-law

☐ Grandparent ☐ Non-Relative ☐ Other ________________________

Primary Language Spoken at Home: ☐ English ☐ Spanish ☐ Other ______________________

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

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, provide **documentation** **of such** AUTHORITY (e.g. POWER of attorney, HEALTH CARE REPRESENTATIVE**, OR 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.**

As a Caregiver, what are some things you need assistance within in fulfilling that role? **(example: "I need help with grocery shopping" :** ______________________________

____

____

Income: *Caregiver income information 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 monthly income is about:
☐ At or Below $1,073 (100%) ☐ $1,074 - $1,342 (125%) ☐ $1,343 - $1,610 (150%)
☐ $1,611 - $1,878 (175%) ☐ $1,879 - $2,147 (200%) ☐ $2,148 or over (over 200%)

I live with my spouse and OUR monthly income is about:
☐At or Below $1,452(100%) ☐$1,453 - $1,815 (125%) ☐$1,816 - $2,178 (150%) ☐$2,179 - $2,540 (175%)
☐$2,541 - $2,903 (200%) ☐$2,904 or over (over 200%**).**

Income / Asset Statement

(This information applies to both programs)

Please list the care recipient's sources of income, including spouse. 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 (20) 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 and indicate with whom it is jointly held.

	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 such as state funded benefits, 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 CARE RECIPIENT. If you are a legally designated REPRESENTATIVE, such as Power of Attorney, Health Care Representative, or Conservator, you may sign on behalf of the care recipient.

DATE

<u>CO-PAYMENT AGREEMENT</u>

(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 may 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. The 20% co-payment will be explained to you by the Area Agency on Aging once your application is received.. This co-payment may be waived based upon demonstrated financial hardship and is determined by the Area Agency on Aging (AAA). I understand that if I have an emergency that makes me unable to pay my fee that I must contact the AAA 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 the AAA.

____

SIGNATURE of CARE RECIPIENT. If you are a legally designated representative, such as Power of Attorney, Health Care Representative, or Conservator, you may sign on behalf of the care recipient.

Date: ____________________

I understand that if I have questions I can call:

Area Agency on Aging

Address

Phone: 203-757-5449

Fax: 203-757-4081

*PHYSICIAN STATEMENT

(*For those whose care recipient has Alzheimer's or related dementia that is irreversible and deteriorating in nature, a physicians statement must be obtained.)

Patient's Name: ____

Date of Birth: ____________________

Address: ____

Phone: ___________________

For Physician use only:

Has this patient been diagnosed with Alzheimer's or related dementia that is irreversible and deteriorating in nature?

☐ **Yes** ☐ **No**

______________________________________ ______________

SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print): ____

Address: ____

____

Telephone: ___________________________

Return to the below contact within 7 business days:
Area Agency on Aging
Address of Aging
Town, State Zip
Phone Number: 203-757-5449
Fax: 203-757-4081

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

CARE RECIPENT 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 CARE RECIPIENT OR AUTHORIZED AGENT

____

DATE

THANK YOU!

Please return to:

Area Agency on Aging
Name
Address
Town, State, Zip
Phone: 203-757-5449
Fax: 203-757-4081