# CAREGIVER SUPPORT SERVICES APPLICATION

Please complete all elements of this application to be considered for caregiver support services. Once the application is completed and submitted, a representative from the Area Agency on Agency that serves your region will be in touch with you. You should be contacted within 5 business days. If you have any questions, please call 1-800-994-9422.

## CAREGIVER'S Information

**This is information about YOU as the Caregiver**

**Caregiver's Name:** _____
(first) (last)

**Today's date:** _____ (XX/XX/XXXX)

**Gender (of the caregiver):** ☐ Male ☐ Female ☐ non-binary ☐ Other

**Marital Status**: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Date of Birth**: ____/___/___ (MM/DD/YYYY)

**Address of Caregiver:** _____ *(Street or PO Box)*
_____ *(City/ST/Zip)*

**Please indicate the BEST phone number to reach you:** _____

**Email address:** _____

**Caregiver's Relationship to Care Recipient** *(Check all that apply)***:**
☐ Mother ☐ Father ☐ Husband/Wife ☐ Domestic Partner ☐ Brother ☐ Sister
☐ Daughter-in-Law ☐ Son-in-law ☐ Son ☐ Daughter ☐ Granddaughter ☐ Grandson
☐ Grandfather*☐ Grandmother* ☐ non-relative ☐ Conservator of Person**
☐ Conservator of Estate**☐ Health Care Representative** or Power of Attorney**
☐ Other _____

**Only check if the caregiver is age 55 or older and is the primary caregiver for a child under age 18 or an adult child between age 18 - 59 with a disability. Non-Relative and Other Relative may be checked for these caregivers as well as caregivers of older adult.*

***If you are authorized to act as legal representative for the care recipient, you will be asked to provide documentation of such authority.*

**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:** American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White–Not Hispanic/Latino ☐ White-Hispanic/Latino ☐ Other: _____

**How did you hear about the Program?** (Check all that apply)

☐ Area Agency on Aging ☐ TV ☐ Radio ☐ Internet

☐ Agency Referral, if so, please indicate which one: _____

☐ Other_____

**As a Caregiver, what do you find the most stressful aspect of your role?** *(example: "Finding time for myself" or "Being able to go to my own appointments")***:**

_____

_____

**As a Caregiver, what are some things you need assistance with to better fulfill your role?** *(example: "I need help with grocery shopping")***:**

_____

_____

**Please use this box for any additional information:**

_____

_____

_____

_____

_____

_____

_____

## CARE RECIPIENT'S Information

**Care Recipient's Name:** (the *"care recipient" is the person for whom you are providing care)*: _____
(first) (last)

**Gender (of the care recipient):** ☐ Male ☐ Female ☐ non-binary ☐ Other

**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Is the care recipient a Veteran or Dependent of a Veteran**: ☐ Yes ☐ No

**Date of Birth:** ____/___/___ (MM/DD/YYYY)

**Address of Care Recipient:** _____ *(Street or PO Box)*
_____ *(City/ST/Zip)*

**Please indicate the phone number of the Care Recipient:** _____

**Town of residence of the care recipient** (if different than mailing address) This is used to ensure your application gets to the AAA that serves your region): _____

**Primary Language Spoken at Home:** ☐ English ☐ Spanish ☐ Other _____

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

**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

**Race:** ☐ American Indian/Alaskan Native ☐ Asian/Asian American ☐ Black/African American ☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ White–Not Hispanic/Latino ☐ White-Hispanic/Latino ☐ Other: _____

**Type of Housing:** (*Please check the one that applies to the care recipient)*
☐ Private home ☐ Private apartment ☐ Senior housing ☐ Congregate housing ☐ Public housing ☐ Residential Care home ☐ Nursing home/Institution ☐ Assisted Living
☐ Other (Please specify): _____

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

☐ Alone ☐ With spouse only ☐ With spouse/partner & children ☐ With partner/unmarried ☐ With children, no spouse/partner ☐ With grandchildren ☐ With other relatives ☐ Other: _____

**Has the Care Recipient been diagnosed with:**

☐ Alzheimer's disease ☐ Early On-Set dementia ☐ Vascular Dementia ☐ Lewy Body Dementia ☐ Frontotemporal Dementia ☐ Mixed Dementia ☐ Parkinson's Disease with dementia ☐ None of the above ☐ I don't know

*(*For those whose care recipient has Alzheimer's or related dementia that is irreversible and deteriorating in nature, the attached physician's statement must be completed.)*

**If there is a diagnosis, what stage?**

☐ Mild ☐ Moderate ☐ Severe ☐ I don't know

**Does the care recipient have a disability?**

☐ Yes *(Please specify)* _____ ☐ No ☐ I don't know

**Name of Primary Physician**: _____

**Telephone:** _____

**Medical Diagnoses (please list all):**

_____

_____

**Any Pets:** ☐ Yes ☐ No If yes, what kind of pets? _____

**Are there any smokers in the home:** ☐ Yes ☐ No ☐ I don't know

**<u>Other Supports</u>**

1. Does the Care Recipient currently receive **MEDICAID (TITLE 19)**?
   ☐ Yes ☐ No ☐ I don't know

   If no, is the care recipient currently applying for **MEDICAID (TITLE 19)**?
   ☐ Yes ☐ No ☐ I don't know

2. Does the care recipient currently receive services from the **CT Home Care Program for Elders**? ☐ Yes ☐ No ☐ I don't know

   If no, is the care recipient currently applying for the **CT Home Care Program for Elders**? ☐ Yes ☐ No ☐ I don't know

3. Does the care recipient require assistance with any of the following **Activities of Daily Living** (ADLs)? *(please check all that apply)*

☐ Eating ☐ Bathing/Washing ☐ Dressing ☐ Toileting ☐ Walking

☐ Continence (Bladder/Bowel Control) ☐ Getting out of bed/chair

4. Does the care recipient receive any *additional* home or community-based services (such as a visiting nurse or going to an Adult Day Center)?

☐ Yes ☐ No ☐ I don't know

If yes, what types of services does the care recipient currently receive and from what agency: _____

_____

5. Does the Care Recipient have challenges with or need help with any of the following Instrumental **Activities of Daily** Living (IADLs)? (*Please check all that apply)* ☐ Planning/Preparing Meals ☐ Shopping ☐ Managing Money ☐ Using Telephone ☐ Housekeeping ☐ Doing Laundry ☐ Taking Medicine ☐ Using Transportation

## CARE RECIPIENT'S Income / Asset Statement

### Care Recipient's Income

Please list the care recipient's total sources of income, including the spouse's or other 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.

- Care Recipient's Monthly Income is: $ _____
- Care Recipient's Spousal Monthly Income: $ _____

*Your Care Manager will use the incomes reported above to determine program eligibility.*

*Note: Spousal income information is used to identify other sources of support such as state funded benefits and is not a determining factor of eligibility.17a-860(c)(1)(A) Conn.Gen.Stat.*

### Care Recipient's Liquid Assets*

Please indicate liquid assets of the care recipient and his or her spouse. Assets owned with others may also be listed. Liquid assets are defined as an asset that

can be converted into cash within twenty (20) business 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. The house that the person resides in does not count as an asset.

- Care Recipient + Spouse is: $_____

**"Liquid assets" means any checking accounts, savings accounts, individual retirement accounts, certificates of deposits, stocks or bonds, that can be converted into cash within twenty working days. Include all accounts in the applicant's name as well as those in both the applicant's and their spouse's name.*

Are there any joint assets? (If you are unsure, your Care Manager may be able to help you to determine): ☐ Yes ☐ No ☐ I don't know

If so what and with whom? (example: care recipient owns a rental property with their sister) _____

## CERTIFICATION AND AUTHORIZATION

**I**, _____, **certify that the information on this form is true, accurate, and complete to the best of my knowledge.**

_____

*Signature Of Care Recipient/Authorized Representative* or Responsible Person applying to the Caregiver Support Program on behalf of the Care Recipient.*

**Today's date:** _____(XX/XX/XXXX)

# PERMISSION FOR RELEASE OF MEDICAL INFORMATION

**CARE RECIPENT OR AUTHORIZED REPRESENTATIVE: Please complete this page and send it, along with the physician's statement, to your physician.**

I, (name of care recipient) _____, agree to the release of medical information to the Area Agency on Aging for the purpose of determining my eligibility for the Caregiver Support Program.

_____
Name of Patient

_____
Address

_____
Phone

_____
Date of Birth (XX/XX/XXXX)

_____ _____
*Signature Of Care Recipient or Authorized Representative** *Today's Date*

_____
*Please print Care Recipient Name clearly*

*An authorized representative is an **adult**, over the age of **eighteen**, who has **written authorization** to act on the behalf of an assistance unit **of which he or she is not currently a member, and who would otherwise not be eligible to act without such authorization**.
***Due to HIPPA, you may need to complete a separate authorization with the designated health care provider***

**Please return to:**
**Western CT Area Agency on Aging**
**84 Progress Lane**
**Waterbury, CT 06705**
**Phone: 203-757-5449 Option 6**
**Fax: 203-757-4081**

## *PHYSICIAN STATEMENT

*(*Complete if care recipient has Alzheimer's or related dementia that is irreversible and deteriorating in nature, a physician's 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**

☐ Alzheimer's disease ☐ Early On-Set Dementia ☐ Vascular Dementia ☐ Lewy Body Dementia

☐ Frontotemporal Dementia ☐ Mixed Dementia ☐ Parkinson's Disease with dementia

☐ N/A No diagnosis of Alzheimer's or Related Dementia

**Date of original diagnosis:** _____

**If there is a diagnosis, what stage?** ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

_____ _____
**SIGNATURE OF PHYSICIAN** **DATE**

Name of Physician (Please Print): _____
Address: _____
_____
Telephone: _____

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