Agency on Aging
of South Central Connecticut
Your Advocate for Independence®

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 2016 US Poverty Guidelines Income Range (% of FPL)	Individual 's Monthly Income	Cost Share Amount
0-100%	$0 to $990	donations accepted
150%	$991 to $1,485	5%
200%	$1,486 to $1,980	10%
250%	$1,981 to $2,475	20%
300%	$2,476 to $2,970	40%
350%	$2,971 to $3,465	60%
400%	$3,466 to $3,960	80%
Over 400%	$3,961 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 **$44,591** a year, or have liquid assets of more than **$ 118,549.**

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

Revised 12/15

Please complete the following application. 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:** _____-____-_____
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 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: ____/___/___ MO/DAY/YR **Social Security Number:** **XXX-XX-**_____ (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 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	$ _____	_____ (*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

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

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 **Agency on Aging of South Central CT**

_____

Signature of Caregiver Date

I understand that if I have questions I can call:

Agency on Aging of South Central CT
Respite Care Department
1 Long Wharf Dr. Suite 1L
New Haven, CT 06511
203-785-8533 (phone)
203-785-8873 (fax)

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 **Agency on Aging of South Central CT**

_____
Signature of Caregiver Date

I understand that if I have questions I can call:

Agency on Aging of South Central CT
Respite Care Department
1 Long Wharf Dr. Suite 1L
New Haven, CT 06511
203-785-8533 (phone)
203-785-8873 (fax)

PHYSICIAN STATEMENT
FOR CONNECTICUT STATEWIDE RESPITE CARE PROGRAM

An application has been made to **Agency on Aging of South Central CT** 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**

_____

SIGNATURE OF PHYSICIAN **DATE**

Name of Physician (Please Print or Type): _____

Address: _____

Telephone: _____

Please return form to:

Agency on Aging of South Central CT
Respite Care Department
1 Long Wharf Dr. Suite 1L
New Haven, CT 06511
203-785-8533 (phone)
203-785-8873 (fax)

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 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 this form to:

Agency on Aging of South Central CT
Respite Care Department
1 Long Wharf Dr. Suite 1L
New Haven, CT 06511
203-785-8533 (phone)
203-785-8873 (fax)