

Caregiver Support Programs Application Cover Sheet

Applicant Name: _____

Date: _____

This cover sheet accompanies the application for the Connecticut Statewide Respite Care Program (CSRPC) and the National Family Caregiver Support Program (NFCSP). These programs offer respite and supportive services to eligible caregivers or care recipients.

Program Eligibility:

CSRPC:

- ✓ The care recipient must have a formal diagnosis of Alzheimer's disease or a related dementia.
- ✓ The care recipient must meet financial eligibility requirements (income and asset limits apply).

NFCSP:

- The caregiver must be providing unpaid care to an individual 60 years or older OR to an individual with Alzheimer's disease or a related disorder (regardless of age).
- OR The caregiver is 60 years or older and provides unpaid care to an adult child with a disability.
- OR Grandparents or older relatives (age 55+) raising grandchildren may also be eligible for support services.

Checklist of Required Documents:

- Completed Application Form
- Proof of Diagnosis (if applicable) – A physician's note, medical record, or other official documentation confirming Alzheimer's or related dementia (required for CSRPC).
- Proof of Age (if required) – Copy of driver's license, birth certificate, or state ID.

Application Submission Instructions:

- ✓ Complete the enclosed application form.
- ✓ Attach the required documents listed above.
- ✓ Submit the completed application to:

Senior Resources Agency on Aging
19 Ohio Ave., Suite 2, Norwich, CT 06360
Phone: 860-887-3561 Fax: 860-886-4736
Email: Aging.Answers@SeniorResourcesEC.org

If you need assistance completing the application,
contact Senior Resources at 860-887-3561.



For more information on CSRPC and NFCSP, please visit:
<https://portal.ct.gov/ads-caregivers>

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 Aging 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/yyyy)

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

Marital Status: Married Divorced Separated Widowed

Date of Birth: / / (MM/DD/YYYY)

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

Other Supports

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 RECIPIENT 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/yyyy)

*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:

Senior Resources Agency on Aging

19 Ohio Ave., Suite 2

Norwich, CT 06360

Phone: 860-887-3561

Fax: 860-886-4736

Email: AgingAnswers@SeniorResourcesEC.org

*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: _____

Please return to:

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