NorthCentral
Area Agency on Aging

151 New Park Avenue, Box 75, Hartford, CT 06106
Phone: 860-724-6443 · 800-994-9422
Fax: 860-251-6107
Website: www.ncaaact.org

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 North Central Area Agency on Aging (NCAAA) 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 2017 US Poverty Guidelines Income Range (% of FPL)	Individual 's Monthly Income	Cost Share Amount
0-100%	0 to $1,005	donations accepted
150%	$1,006-$1,508	5%
200%	$1, 509-$2,010	10%
250%	$2,011-$2,513	20%
300%	$2,514-$3,015	40%
350%	$3,016-$3,518	60%
400%	$3,519-$4,020	80%
Over 400%	$4,021+	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 **$46,897** a year, or have liquid assets of more than **$124,679.**

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 7/19

Please complete the following application. Please do not leave any questions blank.
PLEASE PRINT CLEARLY!

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:** _____-____-_____
Month/ Day / Year

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: ☐ No ☐ Yes (specify: ____)

Primary Physician: ____ **Telephone:** ______________________

Medical Diagnosis: ____

____

____

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)

☐ Bathing ☐ Eating ☐ Dressing ☐ Using the Bathroom ☐ Walking ☐ Moving in and out of bed/chair

5. **Does the care recipient currently receive any home or community based services? If yes, please list the services and indicate how the services are paid for:**

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

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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, State, Zip ____

Email 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 <u>documentation</u> 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.**

Explain the reason the CAREGIVER is requesting assistance: ____

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Describe the type of assistance that is needed: ____

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Additional comments from CAREGIVER:

____

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____

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.

INCOME (Monthly Amount)	Care Recipient	Spouse*	
Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	$ ______	______	
Pensions, retirement income, annuities	$ ______	______	
Veteran's Benefits	$ ______	______	
		Joint? (Y/N)	**With Whom?**
Interest and Dividends	$ ______	______	______
Other income (wages, net rental income, non-taxable income)	$ ______	______	______
TOTAL AMOUNT OF INCOME	$ ______	______	______

*Listing spousal income information is optional; it is used to determine other sources of support and is not a determining factor of eligibility.

LIQUID ASSETS	Amount	Joint? (Y/N)	With Whom?
______	$ ______	______	______
______	$ ______	______	______
______	$ ______	______	______
TOTAL AMOUNT OF LIQUID ASSETS	$ ______	______	______

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

I understand that if I have questions I can call:

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
FAX: 860-251-6107
WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

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 North Central Area Agency on Aging (NCAAA).

____
Signature of Caregiver Date

I understand that if I have questions I can call:

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
FAX: 860-251-6107
WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

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, 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 North Central Area Agency on Aging (NCAAA).

____
Signature of Caregiver Date

I understand that if I have questions I can call:

NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)
151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106
PHONE: 860-724-6443 or 1-800-994-9422
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WEB: www.ncaaact.org
EMAIL: info@ncaaact.org

PHYSICIAN STATEMENT
FOR CONNECTICUT STATEWIDE RESPITE CARE PROGRAM
AND NATIONAL FAMILY CAREGIVER SUPPORT SUPPLEMENTAL SERVICES PROGRAM

CAREGIVER OR AUTHORIZED AGENT:
Please fill out the first two sections of this form and send it to care recipient's physician to be completed.

REQUEST FOR MEDICAL INFORMATION

TO: ____
(PHYSICIAN NAME)

FROM: North Central Area Agency on Aging
860-724-6443 ext. 230

North Central Area Agency on Aging (NCAAA) is assisting the individual named below in obtaining services. In order to evaluate the program options available, information is required regarding the individual's diagnosis and the level of care needed. **Please complete the medical statement below and submit it to NCAAA via fax at 860-251-6107 or mail to 151 New Park Avenue, Box 75, Hartford, CT 06106.** Thank you for your assistance.

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I authorize the health professional named above to release to NCAAA, medical information on:

____ ___________________________
Name of Patient/Care Recipient | Date of Birth

____ ___________________________
Care Recipient Address | Care Recipient Phone

____ ___________________________
Printed Name of Caregiver and Relationship to Care Recipient | Caregiver Phone

____ ___________________________
Signature of Caregiver or Authorized Agent | Date

MEDICAL STATEMENT (TO BE COMPLETED BY PHYSICIAN)

1. **DIAGNOSIS**

   a. Date Patient was last seen: ____________________

   b. Indicate major and minor diagnoses: ____

   ____

   c. Does the patient have irreversible and deteriorating dementia? ________ Yes ________ No

   If yes, specify type of dementia and date of diagnosis: _________________________________

2. **PROGNOSIS**

   a. Is the primary condition/disability permanent? ________ Yes ________ No

   b. If no, what is expected duration of condition/disability? ________________________________

3. **FUNCTIONAL LIMITATIONS & RISK OF INJURY**

   a. Describe physical limitations (if any): ____

   b. Has the patient fallen in the past year (that you are aware of)? ________ Yes ________ No

   If so, how often? _________ Any resulting injuries? ________________________________

   c. Describe any limitations due to mental health: ____________________________________

   d. Is the patient at risk of injuring him/herself? ________ Yes ________ No

4. **NEED FOR COMMUNITY SUPPORT**

   a. In your professional opinion, would this individual benefit from receiving community-based support services (e.g. home care, help with self-care, meals, transportation, etc.)?

   Yes_______ No________ Comments: ____

   b. Is this individual able to reside safely at home, without community support?

   Yes_______ No________ Comments: ____

   c. Is this individual at risk of being institutionalized in a skilled nursing facility?

   Yes_______ No________ Comments: ____

   d. Additional comments on the patient's need for community support services:

   ____

   ____

____ ___________________________

Signature of Physician Date

____ ___________________________

Name of Physician (please type or print legibly) Phone

____ ___________________________

Address Fax