**Central Midlands Council of Governments**

**Area Agency on Aging Respite Application**

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| **Care Receiver Information** | | | | | | | | |
| Last Name: | | | | | First Name: | | | |
| Address: | | | | | | | | |
| County: | | | | | | City: | Zip: | |
| Care Receiver DOB: | Age: | | Race: | | | Gender: | Marital Status: | |
| Has this person used a respite award or voucher before? If so, what program? | |  | | **Level of Ability.**  Please indicate the level of activity for each activity.  Rating each ability below using numbers 0-5.  Level 0-completely independent , Level 1-needs a little assistance, Level 2-needs occasional assistance, Level 3-needs moderate assistance, Level 4-needs substantial assistance, Level 5-total dependence | | | | |
| Do you receive funds or assistance from another agency? | |  | |
| Does this person live alone? | |  | | Ambulation: | | | | Toileting: (includes Bowel and/or Bladder incontinence) |
| Number of persons in household: | |  | | Eating: | | | | Bathing: |
| Do you have help from family or friends with providing care for your loved one! | |  | | Transferring: | | | | Supervision: |
| I Total monthly income of care receiver: | |  | | Dressing: | | | | Can you leave him/or her alone? Yes or No (circle) |

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| **Caregiver Information** | | | | |
| Last Name: | | First Name: | | |
| Relationship to Person with Dementia: | | | Telephone #: | |
| Caregiver DOB: | Race: | | Gender: | Ethnicity: |
| Do you live with the above person needing care? | | | | |
| Do you have a member of the household who is disabled or qualifies as disabled? | | | | |
| Care Receiver’s Physical & Memory Skills or Comments: | | | | |
| **Please check all that may apply to your situation:** | | | | |
| Medicaid Eligible ❑ VA Eligible ❑ Medicare Eligible ❑ Hospice❑ Caregiver Support Program❑ Community Long Term Care❑ Respite Voucher Program ❑ Long Term Care Insurance ❑ | | | | |
| **Please check which respite program you are applying for: (check only one)** | | | | |
| SC State Respite ❑ \*Alzheimer’s Respite ❑ Caregiver Support Program ❑  SC State Respite-caregiver must be 60+, or senior age 55+ raising children.  Alzheimer’s Respite- care recipient must have a doctor statement (see below\*)  Care Giver Support Program- caregiver respite or seniors age 55+ raising children and/or reimbursement for supplemental services, provided funding is available. | | | | |
| **Please check which type of respite you would** **like**: In-Home care with an approved agency❑  Adult Daycare ❑ Short-Term Facility Stay ❑ In-Home worker (non-agency)❑ | | | | |

**\*FOR ALZHEIMER’S RESPITE PROGRAM: PLEASE ATTACH A DIAGNOSIS STATEMENT FROM THE PATIENT’S PHYSICIAN/NEUROLOGIST OR HAVE THE PHYSICIAN / NEUROLOGIST COMPLETE THE DIAGNOSIS SHEET ATTACHED TO THIS APPLICATION. A SIGNATURE FROM THE PHYSICIAN IS REQUIRED. NO LETTER OF AWARD WILL BE ISSUED WITHOUT A STATEMENT OF DIAGNOSIS. *Alzheimer’s Respite Program provided through the partnership with the Alzheimer’s Association.***

* Respite funds are paid after the services are rendered.
* Your Area Agency on Aging must be invoiced by the agency for services and payment will be mailed directly to the agency.
* In-home workers are paid by the caregiver. Caregiver will submit worker timesheets and caregiver will complete W9 to Area Agency on Aging. Central Midlands Agency will mail payment directly to caregiver.

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| **Submitted by (family member) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship to Care Receiver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**The above signature must be a spouse, family member or POA of the person with dementia. This signature authorizes the LGOA, AAAs, and the Alzheimer’s Association to share the information for the provision of services. Please return application and doctor’s diagnosis statement to:**

|  |  |
| --- | --- |
| **Cindy Curtis, LMSW**  **Family Caregiver Advocate**  **Central Midlands Council of Governments**  **Area Agency on Aging, 236 Stoneridge Drive, Columbia, SC 29210**  **Direct Line: 803-744-5134,Fax: 803-376-5394**  [**ccurtis@centralmidlands.org**](mailto:ccurtis@centralmidlands.org) | **C:\Users\Cindy\Documents\AAA\AAA forms\LogoClean_black_myriad (2).tif** |

**Alzheimer’s Disease and Related Disorders**

**Physician Diagnosis Statement**

**STATEMENT OF DIAGNOSIS**

***To be completed & signed by patient’s physician.*** Qualification for the Alzheimer’s Respite Program depends on the patient’s diagnosis. This respite program serves patients with Alzheimer’s disease and related dementias.

**PATIENT INFORMATION** (PLEASE PRINT)

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| Name: |
| Address: |
|  |
| Date of Birth: |
| Name of Caregiver: |

**PHYSICIAN INFORMATION (**PLEASE PRINT NAME)

|  |
| --- |
| Name: |
| Signature: |
| Telephone: |
| Date: |

**PLEASE CHECK ONE OF THE FOLLOWING:**

Alzheimer’s disease

Creutzfeldt-Jakob disease

Vascular dementia

Parkinson’s disease

Huntington’s disease

Pick’s disease

Lewy-Body dementia

Mixed dementia

**Please return application and doctor’s diagnosis statement to:**

**Cindy Curtis, LMSW**

**Central Midlands Council of Governments**

**Area Agency on Aging**

**236 Stoneridge Drive, Columbia, SC 29210**

**Direct Line: 803-744-5134, Fax: 803-376-5394**

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