



## 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 2015 US Poverty Guidelines Income Range (% of FPL)	Individual 's Monthly Income	Couple's Monthly Income	Cost Share Amount
0 – 100%	\$0 to \$981	\$0 to \$1,328	donations accepted
101 – 150%	\$981 to \$1,472	\$1,329 to \$1,992	5%
151 – 200%	\$1,473 to \$1,962	\$1,993 to \$2,656	10%
201 – 250%	\$1,963 to \$2,453	\$2,657 to \$3,320	20%
251 – 300%	\$2,454 to \$2,943	\$3,321 to \$3,984	40%
301 – 350%	\$2,944 to \$3,434	\$3,985 to \$4,648	60%
351 – 400%	\$3,435 to \$3,924	\$4,649 to \$5,312	80%
Over 400%	\$3,925 and over	\$5,313 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 4/15**

**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. Explain the reason that the caregiver is requesting services: \_\_\_\_\_

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5. Explain the type of assistance that is needed: \_\_\_\_\_

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6. Does the care recipient receive any additional home or community based services? If yes, please list the services:

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7. 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR

**Social Security Number:**

XXX-XX-\_\_\_\_\_  
(Last four digits only)

**Address including PO Box's:**

Street and PO Box \_\_\_\_\_

City, State, 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.

<b>INCOME</b>	<b>Monthly Amount</b>	<b>Joint? (Y/N)</b>	<b>With Whom?</b>
Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	\$ _____	_____	_____
Pensions, retirement income, annuities	\$ _____	_____	_____
Veteran’s Benefits	\$ _____	_____	_____
Interest and Dividends	\$ _____	_____	_____
Other income (wages, net rental income, non-taxable income)	\$ _____	_____	_____
<b>TOTAL AMOUNT OF INCOME (CARE RECIPIENT)</b>	\$ _____	_____	_____

<b>LIQUID ASSETS</b>	<b>Amount</b>	<b>Joint? (Y/N)</b>	<b>With Whom?</b>
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
<b>TOTAL AMOUNT OF LIQUID ASSETS</b>	\$ _____	_____	_____



**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.

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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.ncaact.org](http://www.ncaact.org)**

**EMAIL: [info@ncaact.org](mailto:info@ncaact.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](http://www.ncaaact.org)**  
**EMAIL: [info@ncaaact.org](mailto: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**  
**FAX: 860-251-6107**  
**WEB: [www.ncaaact.org](http://www.ncaaact.org)**  
**EMAIL: [info@ncaaact.org](mailto:info@ncaaact.org)**



**PHYSICIAN STATEMENT  
FOR CONNECTICUT STATEWIDE RESPITE CARE PROGRAM**

An application has been made to North Central Area Agency on Aging (NCAAA) 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:



**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**



**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:**



**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**

