Agency on Aging of South Central CT
Respite Services for Caregivers

Caregivers often find that the task of caring for another person can 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 Agency on Aging of South Central CT offers the following types of services for caregivers:

RESPITE CARE: Respite care is a short-term option designed to provide a break from the physical and emotional stress of caregiving.

Respite care services include, but are not limited to: adult day care, home health aide, homemaker, companion, skilled nursing care, short term assisted living, or short term nursing home care. Funds may be used for daytime or overnight respite.

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 people.

Supplemental services include, but are not limited to, home safety modifications and medical related equipment.

Please Note: If you are a grandparent or relative caregiver for a child who is 18 years of age or younger, please complete Connecticut's National Family Caregiver Support Program "Grandparent/Relative Caregiver Application"

Agency on Aging of South Central CT
1 Long Wharf Dr.
New Haven, CT 06511
Phone: 203-785-8533 Fax: 203-785-8873

ELIGIBLE CAREGIVERS

The term 'family caregiver' means an adult family member, or another individual who is an informal provider of in-home and community care.

Only family caregivers who provide care to an older individual with one or more of the following conditions are eligible to receive services under this program:

The care recipient:

1. Must be unable to perform at least two activities of daily living. Activities of daily living include bathing, dressing, toileting, eating, walking without substantial human assistance, including verbal reminding, physical cueing or supervision;
2. Has a cognitive or other mental impairment that requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to him or herself or to another individual;
3. Has 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 one of the above.)

GENERAL PRIORITY GUIDELINES

Priority will be given to:

- Older individuals with greatest social and economic need, with particular attention to low-income older individuals; OR
- Older individuals providing care and support to individuals with severe disabilities, including children with severe disabilities; OR
- Individuals with Alzheimer's disease or an irreversible dementia.

PAYMENTS FOR SERVICES

Services are funded through the National Family Caregiver Support Program and the Connecticut Statewide Respite Program.

The National Family Caregiver Support Program is funded by the Administration on Aging and is operated in partnership with the State of Connecticut Department of Social Services and the Connecticut Area Agencies on Aging.

The Connecticut Respite Care Program is funded by the State of Connecticut Department of Social Services, and is operated in partnership with the Alzheimer's Association, Connecticut Chapter, and the Connecticut Area Agencies on Aging.

Agency on Aging may request a contribution or co-payment of 20% towards the cost of the service.

Direct payment to a caregiver is prohibited.

Please talk with Agency on Aging Respite staff for more details.

INCOME

All income and assets are based on the care recipient NOT the caregiver.

The following are considered income: Social Security (minus Medicare Part B premiums), Supplemental Security, Railroad Retirement income; pensions; wages; interest; dividends; net rental income; veteran's benefits; and any other payments received on a one-time or recurring basis. If accounts or other sources of income, for example rental income, are jointly owned between a care recipient and a spouse, 50% of the total interest income in the account or 50% of the rental income will be counted as care recipient's income.

ASSETS

The following are considered liquid assets: Checking accounts, savings accounts, and individual retirement accounts, certificates of deposits, stocks, or bonds that can be converted into cash within 20 working days. If assets are jointly owned with a spouse, 50% of the total asset value will be counted as the care recipient's asset.

If there is an individual authorized to act on behalf of the care recipient (such as a Conservator or Power Of Attorney), please provide documentation of this designation.

PHYSICIAN STATEMENT

The physician statement must be completed by a physician familiar with the care recipient's condition, even if there is no known diagnosis of dementia.

Please send completed application including all documentation to:

Agency on Aging of South Central CT
1 Long Wharf Dr.
New Haven, CT 06511
203-785-8873(fax)

Questions or additional information, please call:
203-785-8533

APPLICATION FORM

Revised 4-1-08

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

Date of application: ___________________________________

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 (last 4 digits only)

Address, if different from the Caregiver:

____
Street City State Zip

Telephone_____________________________________ (if different than Caregiver)

Care Recipient's Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Care Recipient's Race (Please check all that apply)
☐ Black ☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ White Non-Hispanic ☐ White, Hispanic

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 Arrangements (Please check the one that applies to the care recipient)

☐ Alone ☐ With Spouse only ☐With Spouse & Children ☐ With Children only
☐ Other ____

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Primary Physician: ___________________________ Telephone: __________________

Medical Diagnosis: ____

Any Pets: ______________________ **Smoker**: ☐ Yes ☐ No

FAMILY CAREGIVER INFORMATION

Caregiver's Name: ____

Address: ____
Street City State Zip

P.O. Box or other mailing address: ____

E-mail address: ____

Telephone - Home: ______________________Work: ___________________________

Gender: ☐ Male ☐ Female **Age** ____ **Date of Birth** ___/___/___ **Social Security** _ _ _ _
(last 4 digits)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Care Giver's Relationship to Care Recipient:

☐ Daughter ☐ Daughter in law ☐ Wife ☐ Husband
☐ Son ☐ Son in law ☐ Grandparent
☐ Non-Relative ☐ Other Relative

Care Recipient's Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Care Recipient's Race (Please check all that apply)
☐ Black ☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ White Non-Hispanic ☐ White, Hispanic

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 form, 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**

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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 you are requesting services.________________________________

____

____

5) Explain the type of assistance that you need as a caregiver. _________________________

____

____

____

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

____

____

____

7) Note the name of any agency you are currently using or would like to use.______________

____

____

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INCOME STATEMENT

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, dividends, net rental income, veteran's benefits, and any other payments received on a one-time or recurring basis.

If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

		Monthly Amount	
1.	Social Security (minus Medicare premiums), SSI, and Railroad Retirement	$___________	
2.	Pensions, retirement income, annuities	$ ___________	
3.	Veteran's Benefits	$ ___________	
4.	Interest and Dividends	$ ___________	_______ (joint?)
5.	Other income (wages, net rental income, non-taxable income)	$ ___________	_______ (joint?)
		$ ___________	_______ (joint?)
	TOTAL AMOUNT OF INCOME	$____________ (care recipient)	______ (spouse's portion)

Does the spouse have income separate from the applicant?

NO______ YES______

If yes, approximate amount $_______________

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ANNUAL LIQUID ASSET INFORMATION

Please indicate liquid assets of the care recipient and his or her spouse. Liquid assets are defined by this program to be those assets 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, and bonds. Include all accounts in the applicant's name as well as those in both the applicant and their spouse's name. If the account is jointly owned, indicate so by writing "yes" in the appropriate column.

Liquid Asset	Amount	Joint?
______________________________	$_______________	____
______________________________	$_______________	____
______________________________	$_______________	____
______________________________	$_______________	____
TOTAL AMOUNT OF LIQUID ASSETS	$_______________ (care recipient)	____ (spouse's portion)

Does the spouse have assets separate from the applicant?
_____Yes _____No

If yes, approximate amount $____________

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 or all medical records to ensure that appropriate services are provided by the program.

____

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT　　　DATE

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CONTRIBUTION/CO-PAYMENT AGREEMENT

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 20% contribution or co-payment to help with the cost of the services received. The contribution or co-payment shall be used to replenish program funds and therefore assist other care--giving families. The contribution or co-payment shall be made directly to Agency on Aging of South Central CT.

____

Signature of Caregiver   Date

HOLD HARMLESS STATEMENT

By authorized signature below, I hold Agency on Aging of South Central CT harmless from:

- any malpractice/other liability claims or legal actions resulting from action of sub-contractors acting as direct service providers;
- actions/omissions or other faults association with warranties/maintenance agreements of sub-contractors/providers, instructional use of equipment and/or equipment failure; OR
- care plan judgment made as a result of on-site assessments.

____

Signature of Caregiver   Date

I understand that if I have questions I can call:

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PHYSICIAN STATEMENT

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 an irreversible and deteriorating dementia? Yes ______ No ______

____

SIGNATURE OF PHYSICIAN DATE

Name of Physician (Please Print or Type): ___________________________

Address: ____

Telephone: ___________________________

Please return form to: RESPITE DEPARTMENT

Agency on Aging of South Central CT
1 Long Wharf Dr.
New Haven, CT 06511
Phone: 203-785-8533 Fax: 203-785-8873

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: RESPITE DEPARTMENT

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