Central Midlands Family Caregiver Support Program

Central Midlands Council of Governments

Area Agency on Aging Respite Application

Dear Caregiver,

Thank you for your interest in the Central Midlands Family Caregiver Support Program. This program is part of the National Family Caregiver Support Program and provides services for unpaid family caregivers who meet one of the following criteria.

- Caregivers age 18 and older providing care to individuals 60 years of age and older
- Caregivers of individuals of any age with Alzheimer's disease, dementia, and related disorders
- Older relatives, including parents, age 55 and older providing care to adults ages 18-59 with disabilities

Available services include:

- Information to caregivers about available services
- Assistance to caregivers in gaining access to services
- Individual Counseling, organization of support groups, and caregiver training
- Respite Care – A short-term break for caregivers
- Limited Supplemental Services – Incontinence supplies, assistive devices, etc.

Once you complete this application, please return it to:

Central Midlands Family Caregiver Support Program
236 Stoneridge Drive
Columbia, SC 29210
Fax: 803-376-5394
Email: ashaw@centralmidlands.org

If you have questions about this application, please call 803-376-5390 ext. 311.

Thank you,

Central Midlands Family Caregiver Support Program

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Caregiver Information			
Last Name:		First Name:	
Address:			
City:		State:	Zip Code:
County:		Preferred Method of Contact: Phone Call / Email	
Phone number:		Email Address:	
Date of Birth:	Age:	Race:	Hispanic/Latinx? Yes / No
Gender:		Marital Status:	
Employment Status:		Number of people in your home:	
How long have you been caring for your loved one?			
Are you paid by anyone to provide care for your loved one?			
How many hours per week do you spend caring for your loved one?			
What type of assistance do you provide for your loved one?			
Are you receiving any assistance with your loved one's care? ☐ **Community Long Term Care** ☐ **Medicaid** ☐ **PACE** ☐ **VA services** ☐ **Home health services** ☐ **Hospice care**			
Are you already using an in-home care agency? If so, which one?			
Do you have any specific plans for using respite (ex.- planned vacation, upcoming surgery, etc.)?			

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Care Receiver (CR) Information: **Care Receiver #1**			
Last Name:		First Name:	
Address (if different from caregiver):			
Date of Birth:	Age:	Race:	Hispanic/Latinx? Yes / No
Gender:	Marital Status:	Monthly Income:	
How is the CR related to the CG?			
What medical problems make it difficult for the care receiver to care for themselves?			
Care Receiver #2			
Last Name:		First Name:	
Address (if different from caregiver):			
Date of Birth:	Age:	Race:	Hispanic/Latinx? Yes / No
Gender:	Marital Status:	Monthly Income:	
How is the CR related to the CG?			
What medical problems make it difficult for the care receiver to care for themselves?			
If you are caring for more than two people, please submit additional care receiver information on a separate sheet of paper with your application.			

What type(s) of assistance are you interested in receiving from the Family Caregiver Support Program?

- ☐ Respite (temporary in-home care, temporary adult day care, or short term facility stay)
- ☐ Supplemental Services (Incontinence supplies, assistive tech, etc.)
- ☐ Support Group / Individual Counseling
- ☐ Information and Referral Services
- ☐ Other assistance, please explain:

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Caregiver's Name: _____

Notice of Non-discrimination

The Central Midlands Area Agency on Aging complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CMCOG does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual identity or orientation.

Consent

The information you share in this application is for the purpose of determining eligibility for the Family Caregiver Support Program. Provided information will be documented in the South Carolina Department on Aging's statewide database. This data will be kept confidential, and will not be shared without your permission. General information, without names, may be used for reporting purposes, as required by grantors. You have the right to decline to answer any question on this application. You have the right to rescind this consent at any time verbally or in writing. By signing and submitting this application, you consent to the terms listed above.

I certify that:

1. I am a Caregiver for the Care Receiver(s) listed in this application.
2. All information provided to the Central Midlands Area Agency on Aging is correct to the best of my knowledge.
3. I understand that the maximum amount of funds received in one calendar year will vary depending on the availability of funding.
4. I understand that as a participant in the Central Midlands Area Agency on Aging FCSP, I may be asked to participate in interviews and/or surveys to measure client satisfaction and effectiveness of the program. I also understand that if I choose not to respond it will not affect my eligibility for the program and its benefits.

Signature: _____ Date: _____

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~~ THIS SECTION TO BE COMPLETED BY QUALIFIED PROFESSIONAL ONLY~~
(MD, PA, NP, RN, LPN, MSW, PT, OT, or Certified Case Manager)

Please complete the ADL and continence assessment for _____ (person receiving care) based on your professional opinion and observations.

Please indicate the level of ability for each activity:

ADLS	Independent	Assistive Tech. (No help)	Supervision / Coaching	Limited Assist (Some Help)	Extensive Assistance	Total Dependence
Ambulation						
Dressing						
Eating						
Toileting						
Transferring						
Bathing						
Grooming						

Continence	Continent	Usually Continent	Occ. Incontinent	Freq. Incontinent	Incontinent
Bladder					
Bowel					

Healthcare Professional's Signature: _____ Date: _____

Printed Name, Title: _____

Agency/Contact #: _____

Cognitive Diagnosis

If the care receiver has a cognitive diagnosis, please indicate below:

Cognitive Diagnosis: _____ MD Signature: _____

Due to cognitive impairment, the care recipient requires moderate to substantial supervision, and should not be left alone for extended periods of time. Yes _____ No _____

If you have questions about this form, please call 803-376-5390 ext. 311. Please include this form with all sheets of the application.

Caregiver's Name: _____

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