# Central Midlands Family Caregiver Support Program

## Central Midlands Council of Governments

## Area Agency on Aging Respite Application

Date: _____ Caregiver telephone # _____

Caregiver Name: _____

Care Receiver's Name: _____

Caregiver's Address: _____

Dear _____:

Thank you for your interest in the Central Midlands Family Caregiver Support Program (FCSP). We have several programs under the Family Caregiver Program including the FCSP Respite Program, FCSP Supplemental Services, the South Carolina Caregiver Program (State Respite), and the Alzheimer's Respite Program. Based on your completed application, if you qualify, we will place you in the program you are best qualified for and which program will best meet your needs as a caregiver.

Please complete the enclosed application and return it to my attention. I look forward to hearing from you. If you have any questions, my contact information is below.

Thank you,

**Candice Holloway**
Candice Holloway, MA, CIRS A/D
Family Caregiver Advocate
Area Agency on Aging
Central Midlands Council of Government



Central Midlands Council of Governments - Area Agency on Aging
236 Stoneridge Drive, Columbia, SC 29210. (803)376-5390. FAX (803)376.5394

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## Area Agency on Aging Respite Application

| 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? (Yes or No) | | | Does this person receive funds or assistance from another agency? | | Who does this person live with full-time?<br><br>No. In Household: |
| **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? (Yes or No) | Does this person receive funds or assistance from another agency? | | | | Who does this person live with full-time?<br><br>No. In Household: |
| **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? (Yes or No) | Does this person receive funds or assistance from another agency? | | | | Who does this person live with full-time?<br><br>No. In Household: |
| | | | | | |



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## Caregiver or Grandparent Information

| | | | | |
|---|---|---|---|---|
| Last Name: | | First Name: | | |
| Relationship to the person you care for: | | Telephone #: | | |
| Caregiver's Address(If different from Care Receiver): | | Marital Status: | | |
| Caregiver DOB: | Race: | Gender: | Ethnicity: | Do you work? FT or PT? |
| Do you live with the above person needing care? | | | | |
| Do you have a member of the household who is disabled or qualifies as disabled? | | | | |
| What kind of help do you give to the care-receiver? What are the care recipient's medical and/or physical needs? | | | | |

**Please check all current services your care recipient is receiving: Please let us know if you've been in the Caregiver Support Program, or have received a respite voucher in the past.**

Medicaid ❑ VA ❑ Medicare ❑ Hospice ❑ Caregiver Support Program ❑ Home Health ❑ Community Long Term Care-CLTC ❑ SC Respite Coalition Program ❑ Palmetto Senior Care ❑ Long-term care insurance ❑

**Please note the following requirements for our respite programs. You may only qualify for one program and you will be placed in the program that best serves your needs.**

**Serving Caregivers with Greatest Need**

1.) Family caregivers who provide care for any individual with Alzheimer's disease or related disorders with neurological brain dysfunction regardless of age of the person with dementia.
2.) Caregivers of persons age 60 or older with health problems.
3.) Older relative caregivers providing care to adult children with disabilities, if child is 60 year of age or older.

Page 3



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## Area Agency on Aging Respite Application

**Please check which type of respite or supplemental services you would like**:

In-Home care with an approved & licensed agency ❑ Adult Daycare ❑ Short-Term Facility Stay ❑

Supplemental (or Incontinence) Supplies ❑

***Respite funds may be used for respite at an Adult Daycare, for In-Home Care with an approved agency, or a short-term stay in a facility. Do not spend the voucher funds before you receive the voucher or before the isued date on the voucher.***

****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 a partnership with the Alzheimer's Association.***

**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:**

**Candice Holloway, MA, CIRS A/D**
**Family Caregiver Advocate**
**Central Midlands Council of Governments**
**Area Agency on Aging, 236 Stoneridge Drive Columbia, SC 29210**
**Direct Line: 803-744-5152, Fax: 803-376-5394**
**cholloway@centralmidlands.org**

# Central Midlands Family Caregiver Support Program
## Central Midlands Council of Governments
## Area Agency on Aging Respite Application

Caregiver's Name: _____

Care Receiver Name: _____

1. I certify I am responsible for the care of the Care Receiver, who lives in the Central Midlands Region (Lexington, Richland, Newberry & Fairfield Counties), and I am the primary responsible person providing or directing his/her care.

2. I certify all information provided to the Central Midlands Area Agency on Aging FCSP staff is correct to the best of my knowledge.

3. I certify I have provided a complete list of all members of the household, and understand that no one who lives in the household may receive FCSP funds or respite funds for providing services. I further understand that if I break this rule or provide incorrect or fraudulent information or the misuse of funds, I may be permanently terminated from this program.

4. I understand my participation in cost sharing is voluntary. My level of participation depends on my willingness and ability to share in the cost of the service.

5. I understand to promptly (within 7 working days) notify the Caregiver Advocate of changes in situation (major health changes, hospitalization, change of address or phone number, change in respite of either the Care Receiver, grandchildren I am responsible for, or myself).

6. I am willing to abide by the guidelines of the FCSP, including making choices of providers and resources, following the required hiring procedures, completing monthly forms and sending them in for reimbursement (within 30 days for date of service or purchase). I have been informed of my responsibility (if any) regarding IRS and Labor laws.

7. I understand the maximum amount of funds received in one calendar year will vary depending on available funding; no more than $500 may be paid to a caregiver in a calendar year. I understand it is my responsibility to pay the providers of the services I choose if hiring a non-agency worker. I understand that if I use a non-agency worker, I will be responsible for the taxes incurred on any amount paid to me over $599. A 1099 will be issued for amounts over $600 per calendar year.

8. I understand I will be given forms to complete and return monthly to the Caregiver Advocate for pre-approved expenses by the Central Midlands Agency on Aging's Caregiver Advocate. Additionally, if any FCSP funds or respite funds are misused or used for unauthorized services or items, I may be permanently terminated from the program. I have been informed of my rights and responsibilities as a client in the FCSP.

9. I understand the Central Midlands Area Agency on Aging FCSP and other respite programs is a caregiver directed program and I will be requested 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.

(CG)Signed: _____ Date: _____



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**~~ THIS SECTION TO BE COMPLETED BY QUALIFIED PROFESSIONAL ONLY~~**

(Doctor, Licensed Nurse, Social Worker, PT, ST or OT or Case Manager; Note: CNA's are not qualified to determine the information required in this form.)

Please complete the assessment for _____ (person receiving care) based on your professional opinion. Form(s) must be returned to the Family Caregiver Support Program for eligibility evaluation.

Please indicate the level of ability for each activity:

| ADLS | 0 Independent | 1 Assistive Tech. | 2 Supervision | 3 Limited Assist | 4 Extensive Assist | 5-Total Dependence |
|---|---|---|---|---|---|---|
| Ambulation | | | | | | |
| Dressing | | | | | | |
| Eating | | | | | | |
| Bathing | | | | | | |
| Toileting | | | | | | |
| Grooming | | | | | | |
| Bowel | | | | | | |
| Bladder | | | | | | |
| Transfer | | | | | | |

Due to cognitive or other mental impairment, the care recipient requires moderate to substantial supervision because he or she behaves in such a manner that poses a health or safety hazard to him/herself or others.

Yes _____ No _____

*Cognitive Diagnosis: _____ MD Signature_____

** A diagnosis of Alzheimer's or a related memory disorder disease is required for Alzheimer's respite funding.*

❑Alzheimer's disease ❑Creutzfield-Jakob disease ❑Vascular dementia ❑Parkinson's disease

❑Huntington's disease ❑Pick's disease ❑Lewy-Body dementia ❑Mixed dementia

To the best of my knowledge, this family is _____ or is not _____ receiving other types of services in the home at this time. These services might include home health, CLTC, VA, or other types.

Completed by: _____ _____

Healthcare Profession's Signature (not the caregiver) Date

_____ _____

Printed Name Agency

_____ _____

Title Contact Number



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