This information is important. If you do not understand it, take it to your local office for help.

Ces informations sont importantes. Si vous ne les comprenez pas, apportez-les à votre bureau local pour reçevoir de l'aide. **French**

Это важная информация. Если она Вам непонятна, возьмите это письмо и обратитесь за помощью в местное отделение. **Russian**

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć. **Serbo-Croatian**

Esta información es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda. **Spanish**

Maelezo ya barua hii ni muhimu. Kama huielewi, ichukue, uende nayo katika ofisi yako ya karibu kwa msaada zaidi. **Swahili**

Thoâng tin naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ. **Vietnamese**

FY 2024 APPLICATION FOR THE DEMENTIA RESPITE GRANT PROGRAM

Date of Application: ________________

I. CARE RECIPIENT INFORMATION
(Please provide the following information about the individual with dementia)

Preferred Name of Care Recipient: ____

Legal Name of Care Recipient (if different): ____

Residential Address
P.O. Box or Street: ____
City/Town: _________________________ State: Vermont Zip: _____________
County of residence: ____________________________________

Mailing Address (if different from above)
P.O. Box or Street: ____
City/Town: _________________________ State: Vermont Zip: _____________

Phone: (802) __________________________ Alternate Phone:__________________________

Gender: Female_____ Male_____ Self-defined________________________

Age: _____ DOB: ____/ ____/ ____

Marital Status: (check one) ____Married/Civil Union ____Single ____Divorced _____Widowed
______________________________Self-defined (please define)

Income: (Answer only one of these questions)

Indicate the *care recipient's* gross monthly $___________ or gross annual income? $__________

OR if legally bound (e.g., married, civil union, tax dependent), indicate the gross monthly *household* income $___________ or gross annual *household* income $____________.

(Please include a copy of your social security statement and two months of bank statements)
Diagnosis:
Does the care recipient have a physician's diagnosis of Alzheimer's disease? _____Yes _____ No

If no, is there a physician's diagnosis of another progressive, irreversible dementia? _____Yes _____No
(Please include a letter of diagnosis from your medical provider, with this application)

Other Services:
Has the care recipient *applied* for the Choices for Care Medicaid Program? ____Yes ____ No
Does the care recipient *receive services* through Choices for Care? ___Yes ____ No

Does the care recipient *receive services* through the VA VDP program? ___Yes ____No

Has the care recipient *applied* for the Attendant Services Program? _____Yes ____ No

Does the care recipient participate in an Adult Day Program? _____Yes ____No
If yes, indicate source of payment: ____ Respite Grant funds _____Private pay ____ Medicaid _____VA
Other program source (please specify) ____

II. PRIMARY UNPAID CAREGIVER (GRANT APPLICANT) INFORMATION
Please provide information about the primary unpaid caregiver.

Preferred Name of Primary Unpaid Caregiver: ____

Legal Name (if different): ____

Residential Address (if different from care recipient)
P.O. Box or Street: __________________________
City/Town: ____________________ State: ______________ Zip: _____________
County of residence: __________________________________

Mailing Address: (address where communication about dementia respite program will be mailed)
P.O. Box or Street: __________________________ City/Town: ____________________
State: ______________ Zip: _____________

Email Address: ______________________________Do you wish to receive information/education on support groups, websites, etc. Yes / No

Daytime phone: (____) _______________ Evening phone: (____) ____________
If daytime phone is work #, is it permissible to leave messages at this number? ____Yes ____No

Gender: F____ M ____ Self-defined ______________________________________

Age: ____ DOB: ____/ ____/ ____

Marital Status: (check one) ____Married/Civil Union ____Single ____Divorced ____Widowed
_____Self-defined (please specify) :______________________________

Ethnicity of Primary Unpaid Caregiver*	
Hispanic/Latino	
Not Hispanic/Latino	

Not Reported	
Race of Primary Unpaid Caregiver*	
White (Alone) Non-Hispanic	
White (Alone) Hispanic	
American Indian/Alaska Native (Alone)	
Asian (Alone)	
Black/African American (Alone)	
Native Hawaiian/Other Pacific Islander (Alone)	
Person Reporting Some Other Race	
Person Reporting 2 or More Races	
Not Reported	

Primary Unpaid Caregiver Relationship to Person with Dementia:

PRIMARY UNPAID CAREGIVER (Relationship of primary unpaid caregiver to care recipient)	Check one only
Wife	
Husband	
Significant other / partner	
Daughter / Daughter-in-law	
Son / Son-in-law	
Grandchild / great-grandchild	
Brother / Sister	
Parent	
Other relative:	
Non-relative (e.g., friend, neighbor, church member)	

PRIMAY UNPAID CAREGIVER PROFILE	Please check all that apply
I provide care weekly or more (daily).	
I assist my care receiver with Activities of Daily Living (ADLs) – bathing, grooming, toileting, dressing, eating, positioning, or transferring from one location to another within the home.	
I am employed but have had my employment affected by caregiving responsibilities.	
I have quit or lost employment due to caregiving responsibilities.	
I need additional education/training to help with my caregiving.	
I am solely responsible for caregiving responsibilities.	
I need assistance or support for taking care of my own needs.	

I am also providing care to another individual (including children).	
I have a chronic health condition or have had a recent health crisis.	
The stress or burden of caregiving is the primary need I wish to address.	

III. ADDITIONAL QUESTIONS

REASONS FOR NEEDING RESPITE	Check all that apply
Relief from caregiving (short term residential or in-home care/limited basis)	
Assistance providing higher level of care in home regularly (agency services)	
Financial assistance for supplemental services (includes home modifications, assistive technologies, emergency response systems, and incontinence supplies)	
Pay for ongoing regularly scheduled care for caregiver to continue employment	
Pay for regularly scheduled Adult Day services	
Pay for ongoing self-directed care (hiring private/non-agency help)	
Other (specify)	

INTENDED USES OF RESPITE FUNDS	Check all that apply
Personal Care / Assistance with Activities of Daily Living (ADLs)	
Homemaker Services / Chore	
Companion Services	
Substitute In-home Respite	
Home Health Care (Medical/Health Maintenance)	
Adult Day	
Short-term Care in Residential / Nursing Home Care	
Caregiver Counseling / Support / Training	
Transportation	
Assistive Technology	
Home Modification	
Other:	

Referral Source Contact Person: ______________________ **Contact Phone Number:** _________________

IV. RELEASE OF INFORMATION

I give my permission for Senior Solutions Council on Aging for Southeastern Vermont to share the information provided on this application with the organizations that may offer information about support groups, education programs and / or other services that may be of assistance to my family member or me.

Care Recipient's Signature: ______________________________________ Date: ____/____/____
(if available and able to sign)

Primary Caregiver Signature: ______________________________________ Date: ____/____/____