Dementia Caregiver Respite Grant

Application Process

1) ELIGIBILITY

The care recipient (patient):

- Can be of any age
- Must reside in Arkansas
- Must have a primary or secondary diagnosis on doctor's letterhead of Alzheimer's and/or any other dementia. Additionally, the diagnosis must state that the patient requires daily assistance, be signed by the doctor, and dated within a year of submitting the application.

2) APPLICATION

The amount of financial assistance given per grant approval is **$500**. A family may receive this grant twice a calendar year with 6 months between approval dates. For questions, or to request an application, call 501-224-0021 ext 210, visit ALZark.org/grants, or email grants@ALZark.org. The application is a total of four (4) pages, including this page, and all questions must be answered.

3) APPROVAL

To be considered for approval, the application and pre-survey must be fully completed, signed, and include a diagnosis of any dementia on a physician's official letterhead or prescription pad. It will take up to **10** business days to process your application. An eligible application does not guarantee approval. Funds are limited to the number of processed applications submitted during the grant period. Alzheimer's Arkansas cannot guarantee the availability of funds throughout the entire grant period. If your application is approved, you will receive via mail an approval letter, a Respite Survey Log and payment via check. Applications can be submitted via mail, email, or fax:

Mail: Alzheimer's Arkansas
201 Markham Center Dr
Little Rock Arkansas 72205

Email: grants@alzark.org

Fax: 501-227-6303

4) COVERAGE

This grant may be used to pay for respite care services **ONLY**. This includes services such as:

- in-home care
- temporary daycare
- short-term facility stays

This grant and/or funds cannot be used as self-payment to the family caregiver to provide care to the patient.

The grant funds will be paid in full via check to the applying caregiver. The check will be sent with the approval letter and a respite log/survey. After receipt and use of grant funds, applicants must submit the respite log/survey no later than 90 days from the approval date. This survey can be submitted via mail, email, or fax. Failure to submit the survey will result in the disqualification of any future Alzheimer's Arkansas grants.

Dementia Caregiver Respite Grants are limited to the amount of funds available. This mini-grant project is funded through the Arkansas Lifespan Respite Coalition and the Administration on Community Living.

Dementia Caregiver Respite Grant

GRANT PERIOD April 2022 to June 2023

PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY

Caregiver Information (unpaid person providing care to patient)

Caregiver Legal Name: _____
First Middle Last

Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____ Age: _____ Gender: ☐ Male ☐ Female
Month Day Year

Physical Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

*Your answers to the following questions **do not** affect eligibility status of receiving this grant; however, each question must be answered.*

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

Military Status:
☐ Active Duty
☐ Retired
☐ Veteran
☐ None

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race:
☐ White
☐ Black/African American
☐ American Indian
☐ Asian
☐ Hispanic
☐ Other

Relationship to the patient: _____

How many hours of care do you provide daily? _____

How did you hear about this grant? _____

Employment Status: ☐ Employed ☐ Unemployed

Annual Household Income: $_____

Have you received a respite assistance grant in the past 12 months? ☐ Yes ☐ No

If so, from where? _____

For what kind of respite assistance are you applying:
☐ In Home Care ☐ Temporary Day Care ☐ Short-Term Facility Stay

Your privacy is important to us, please visit ALZark.org/grants to view our full privacy statement. Are there any individuals, other than you, with whom we may share grant information? Please list in the space below:

_____

Dementia Caregiver Respite Grant

GRANT PERIOD April 2022 to June 2023

PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY

Care Recipient (Patient) Information

Care Recipient Legal Name: _____
First Middle Last

Date of Birth: ____ ____ /____ ____ / ____ ____ ____ ____ Age: _____ Gender: ☐ Male ☐ Female
Month Day Year

Physical Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

*Your answers to the following questions **do not** affect eligibility status of receiving this grant; however, each question must be answered.*

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

Military Status:
☐ Active Duty
☐ Retired
☐ Veteran
☐ None

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race:
☐ White
☐ Black/African American
☐ American Indian
☐ Asian
☐ Hispanic
☐ Other

Patient Diagnosis: _____

Does the patient live alone: ☐ Yes ☐ No

Patient Primary Speaking Language: _____

Has the patient received/currently utilizing any DHS Waiver or State Plan Service Programs? _____

This application must be submitted with a primary or secondary diagnosis on doctor's letterhead of Alzheimer's or any other dementia. Additionally, the diagnosis must state that the patient requires daily assistance, be signed by the doctor, and dated within a year of submitting the application.

For what kind of respite assistance are you applying:
☐ In Home Care ☐ Temporary Day Care ☐ Short-Term Facility Stay

Are there any individuals, other than you, with whom we may share grant information? Your privacy is important to us, please visit ALZark.org/grants to view our full privacy statement. Please list in the space below:

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PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY

Pre-Funding Survey

Please answer the following questions regarding the grant application process. Please be objective – all comments are helpful! The information you provide will help us to better our application process, as well as helping us understand the needs of Arkansas Caregivers. Your answers **do not** affect eligibility for receiving this grant.

Please rate the level of burden paying out-of-pocket for respite care is on your family: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Please rate the level of ease in applying for this grant: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Please rate your current stress level: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Low High

Have you received respite prior to applying for this grant? ☐ Yes ☐ No

CAREGIVER SIGNATURE:

I have read the above information and completed the application. The information I have provided is correct to the best of my knowledge. Furthermore, I understand that:

- My grant may be denied and/or returned to me if I have made any false or incomplete statements
- The grant funds may only be used to hire a 3rd party provider (professional or personal) to provide respite. **These funds cannot be used to pay myself to provide care to the patient.**
- Alzheimer's Arkansas is not liable for any negligent services provided by the care provider of my choice
- This grant is limited to available funds. Alzheimer's Arkansas may not be able to provide grants throughout the full grant period if allotted funds are used before my application is processed
- It will take up to 10 business days to process my application
- I will receive a survey/log with my grant approval, and I will return it upon completion of the services paid for by this grant. If I do not return this survey, I will not be eligible for future grants offered by Alzheimer's Arkansas

_____ _____

Signature of Caregiver Date