*ALZHEIMER'S ASSOCIATION, CONNECTICUT CHAPTER*
*RESPITE GRANT FUND*

## The Need for Respite

Respite care is a service designed to provide a break, or time of caregiver relief, from the constant physical and emotional stress of caring for a person with Alzheimer's disease. Family caregivers generally find that the task of caring for an Alzheimer's disease patient is overwhelming. They often develop stress-related illnesses such as heart disease, hypertension, or ulcers. An occasional break from care giving enables an exhausted caregiver to regroup both physically and emotionally, and find the strength to carry on.

Respite care is an invaluable service, which truly saves caregivers lives. With financial assistance, many family caregivers who would not otherwise use this service will have the opportunity to obtain temporary relief for them, and may be able to care for their Alzheimer's loved ones at home much longer than would otherwise be possible.

## Purpose of the Fund

The Alzheimer's Respite Fund is subsidized from individual and corporate donations, foundations, trusts and our annual fund-raiser, Memory Walk. It is a financial reimbursement program designed to assist care giving families in accessing respite care services. It provides up to $500 per family per year. Eligible families may purchase any of the following respite care services: adult day program, home health aide, homemaker/companion, skilled nursing care, short-term assisted living stay or short-term nursing home stay. Funds may be used for daytime or overnight respite. It is the family's responsibility to arrange for respite care services through a licensed and bonded agency. The staff and volunteers of the Alzheimer's Association, Connecticut Chapter will assist families, if necessary, in locating appropriate services providers. Reimbursement will be made directly to the service provider after receipt of purchase is submitted to the Connecticut Chapter.

## How to Qualify

There are no income requirements for program eligibility.

The patient **may not** be:

- receiving Title 19 (Medicaid) for the same respite care service
- participating in the Connecticut Homecare Program for Elders (CCCI), Connecticut Statewide Respite Care Program (Area Agency on Aging), or the National Family Caregivers Support Program for the same respite care service.

The primary caregiver **must**:

- reside with the patient in the state of Connecticut
- provide a statement from a physician that the patient has Alzheimer's disease or another type of dementia
- utilize a respite provider contracted through a licensed or bonded agency

For further information and application form, see attached or call the Connecticut Chapter toll free at 1-*800-272-3900.* The program is administered by Maria Tomasetti, Hamden Office, 1-203-230-1777, ext. 14.

**CONNECTICUT CHAPTER**
**RESPITE APPLICATION FORM**

Today's Date: _____

Name of applicant (Person with Dementia):_____

Address: _____
street # city state zip

Telephone: home (_____) _____work (_____)_____

Age: _____ DOB: ___/___/___ Social Security #: _____-_____-_____

Martial Status: Married: ____ Widowed: _____ Single: _____ Divorced: ____ Separated:_____

Does the applicant currently have Medicaid (Title 19)? Yes ____ No ____

If no, has a Medicaid application been submitted? Yes _____ No _____

Is the applicant currently receiving financial assistance? Yes _____ No _____

If yes, from where is the applicant receiving financial assistant? _____

Has the applicant received this grant before? If yes, when? Yes ___ Date ___/___/___ No _____

Name of primary caregiver: _____

Relationship to applicant: _____

Address, if different: _____
street city state zip

Telephone: (_____)_____(_____)_____
Home (if different than applicant) Work

People living in the household with the applicant:

| Name | Sex | Age | Relationship (to patient) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Name and telephone of physician who will verify dementia diagnosis:
_____

Agencies/individuals currently providing services, please list the agency/individual, telephone number, type of service, and how service is being paid for: _____
_____

Reason for respite: _____
_____
_____
_____

Type of respite requested and hours: Homecare, adult day care, in-patient respite, etc. (Example: adult day care, one day a week for 10 weeks)_____
_____
_____

What licensed and bonded agency will you be using with the grant? Please include name, location, and telephone number. _____
_____
_____

**To the professional who may be assisting the family with this application: It would be beneficial if you would complete this section. We could certainly use your help to clarify any questions we may have.**

Name: _____ Position: _____

Agency: _____

Phone Number: _____ Extension: _____

**Return Completed Application to:**

The Alzheimer's Chapter Respite Fund
Alzheimer's Association, Connecticut Chapter
200 Executive Blvd., Suite 4B
Southington, CT 06489

# DOCTOR'S STATEMENT

An application has been made for respite care financial assistance through the Alzheimer's Association, Connecticut Chapter for the individual named below. In order to evaluate the application for the Alzheimer's Respite Fund, information is needed regarding the disability, health and medical problems, and the level of care of the individual. Please answer the following questions and return the form to:
Alzheimer's Association, Connecticut Chapter, 2075 Silas Deane Highway, Suite 100, Rocky Hill, CT 06067.

Person with Dementia's Name: _____

Date of Birth: _____

Address: _____

Does this person have Alzheimer 's disease or a related dementia?

Yes _____ No _____

Other diagnoses: _____

_____

Does this person require supervision of or assistance with activities of daily living?

Yes _____ No _____

Signature of Physician: _____ Date: _____

Name of Physician (Please Print or Type): _____

Address: _____ Office Telephone Number: _____

**Return Completed Form to:**

The Alzheimer's Chapter Respite Fund
Alzheimer's Association, Connecticut Chapter
200 Executive Blvd., Suite 4B
Southington, CT 06489

**TO RESPITE CARE APPLICANT:**

Please complete this page and send it, along with the Doctor's Statement, to the doctor treating the person with Alzheimer's disease or a related disorder.

## PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information on:

Name of Person with Dementia

Address

Birth date

Date

Signature of person with dementia or family member

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Alzheimer's Association, Connecticut Chapter
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