OFFICE USE ONLY

Date Rec'd Application _________ Physician Statement ______
Acceptance ___YES ___NO
Waiting List ___YES ___NO
___ J.E.

IN-HOME RESPITE CARE ASSISTANCE APPLICATION

PRIMARY CAREGIVER LIVING WITH PERSON WITH DEMENTIA

First Name ____ Last Name __________________________________

Male ________ Female ______

Birth Date of Caregiver ______/_____/______

Address ____ City _______________________________________

State ____________________ Zip ____________________ County ____________________________________

E-mail address ____

Home Phone ( ) _________________________ Cell ( ) ______________________________________

Would you like to be called at: ☐Home ☐Work If at Work, hours to be called ________________________

The year you became a Caregiver ____

Your relationship to Person with dementia ☐ husband ☐wife ☐ significant other

☐ son/son-in-law ☐daughter/daughter-in-law ☐ sibling ☐ parent ☐ other relative ☐ non- relative

Which of the following best describes the ethnicity of the primary caregiver?

☐ Hispanic/Latino
☐ Not Hispanic or Latino

Which of the following best describes the race of the primary caregiver?

☐ White - non Hispanic
☐ White - Hispanic
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race
☐ 2 or More Races

PERSON WITH DEMENTIA

First Name ________________________________ Last Name ______________________________________

Birth Date of Person with dementia _______/______/_______

Male __________ Female__________

Does the person with dementia currently receive Hospice services at home? ☐Yes ☐No

Which of the following services does the person with dementia currently receive? Check ALL that apply.

- ☐ Adult Day Center Services
- ☐ Companion or friendly visitor
- ☐ Home Health Nursing Visits
- ☐ Personal Care (bathing, dressing)
- ☐ Short-term Respite in a Health Care Facility

Which of these is closest to the annual income of the person with dementia?

- ☐ Under $8,000
- ☐ $8,000 - $15,999
- ☐ $16,000 - $23,999
- ☐ $24,000 - $31,999
- ☐ $32,000 and over
- ☐ Not reported

Please check **one** box in **each category** that most often describes the capabilities of the person with dementia.

Eating

1. Needs no assistance - feeds self except for minor help with cutting meat, etc. ☐
2. Needs assistance or prompting to get food from plate into mouth ☐
3. Difficulty remembering to chew and/or swallow, or tube feeding ☐

Dressing

1. Needs no assistance – dresses self ☐
2. Needs some help getting in/out of and fastening clothing ☐
3. Needs complete assistance with dressing ☐

Bathing

1. Needs no assistance; gets in/out of bath/shower alone ☐
2. Needs guidance and supervision getting in/out of bath/shower ☐
3. Needs total assistance ☐

Toileting

1. Needs no assistance - gets on and off toilet and cleans self ☐
2. Needs prompting/supervision getting to and using toilet and cleaning ☐
3. Cannot control bladder and/or bowels ☐

Transferring

1. Needs no assistance - gets in/out of bed or chair independently ☐
2. Needs assistance in getting in/out of bed and chair ☐
3. Is confined to bed ☐

Walking

1. Needs no assistance – walks independently or with walker or cane ☐
2. Needs assistance/directions/prompting with walker, cane, wheelchair ☐
3. Is confined to bed ☐

Which of the following best describes the ethnicity of the person with dementia?

- ☐ Hispanic/Latino
- ☐ Not Hispanic or Latino

Which of the following best describes the race of the person with dementia?

- ☐ White – non Hispanic
- ☐ White - Hispanic
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ 2 or More Races

I understand that the Alzheimer's Association recommends that I contact and receive at least two acceptable references for any independent care provider I hire.

I understand that the role of the Alzheimer's Association Respite Reimbursement Program is solely to provide assistance in the form of financial reimbursement for respite care and/or for approved medications and supplies required by my loved one at home. The Alzheimer's Association provides neither management nor direction for respite care received by me or by any member of my family. Accordingly, I release the Alzheimer's Association Mid-Missouri Chapter and the National Alzheimer's Association from any responsibility for any such care provided.

I understand the information on this form to be correct as of ______________________________________
(Today's Date)

____

Signature of Primary Caregiver living with the person with dementia

Complete and mail or fax this form to:
Alzheimer's Association Mid-Missouri Chapter
2400 Bluff Creek Drive, Columbia, MO 65201-3554
Phone: 573-272-3900 Fax: 573-499-9701

RESPITE CARE SERVICES PROGRAM – PHYSICIAN'S STATEMENT
Alzheimer's Association Mid-Missouri Chapter

Name of Primary Caregiver living with Person with dementia ______________________

Name of Person with dementia ______________________

Address ______________________

City ______________________ State ____________ Zip Code ______________

Name of Physician ______________________ Specialty ______________________

Address ______________________

City ______________________ State ____________ Zip Code______________

Office Phone ______________________ Fax ______________________

To qualify for the Alzheimer's Association Mid-Missouri Chapter Respite Reimbursement, a diagnosis of probable Alzheimer's disease or a related disorder is required. **Acceptable diagnoses include: Alzheimer's disease, vascular dementia (multi-infarct dementia), Parkinson's/dementia, Pick's disease, Lewy Body disease, Huntington's disease, Creutzfeldt-Jacob disease, Binswanger's disease, Cadisil, Cortical Basal Ganglionic Degeneration, Fragile X Syndrome, or Progressive Supranuclear Palsy.**

Symptoms of dementia as the result of other causes do not qualify.

DIAGNOSIS: ______________________ Date of Diagnosis: ______________________

Do you recommend respite care services for the person living with this patient? ☐Yes ☐No

If yes, check as many as are appropriate:

☐Adult day care ☐In-home services ☐Short-term nursing home care

Comments: ______________________

____

____

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Physician's Signature: ______________________ Date: ______________________

Caregivers will select and make their own arrangements for services.

Return this completed form to:

Alzheimer's Association
Mid-Missouri Chapter
2400 Bluff Creek Drive
Columbia, MO 65201-3554

Telephone: 573-272-3900
FAX: 573-499-9701