**Midlands Chapter**

1941 S. 42nd Street, Suite 205
Omaha, NE 68105

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24/7 Contact Center: 800.272.3900

**www.alz.org/midlands**


**For Office Use Only**

| | Date: | Initialed By: DG | CF | $ Amount: |
|---|---|---|---|---|
| Application Form Complete: | | | | |
| Physician Statement Complete: | | | | |
| Call or E-mail of Acceptance: | | | | |
| Receipts Received: | | | | |
| Reimbursement Authorized: | | | | |
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| Reimbursement Authorized: | | | | |

# Application Form for Respite Care Reimbursement—2012

**Purpose:**
This program seeks to provide reimbursement for respite services for caregivers of a person disabled with Alzheimer's disease or other dementias. Respite service funding is intended for adult day services, in-the-home respite care, or short-term placement in a care facility.

**Eligibility:**

- Completed Application Forms will be considered.
- Recipients may not be on Medicaid or recipients of other Alzheimer's grants.
- Individuals with the dementing disorder must reside in Douglas and Sarpy Counties.
- Individuals with the dementing disorder must reside primarily in their home setting.
- Physician statement of diagnosis of the dementing disorder must be provided.
- Relatives or members of the same household do not qualify for care provider reimbursement.

**Reimbursement Guidelines:**

- The primary caregiver is responsible for selection, arrangements for service and payment of the respite provider.
- In home respite care and/or companionship must be provided by reputable homecare provider.
- **Up to a maximum of $780** may be provided during the grant period—**January 15th thru October 31, 2012** or until funds are depleted.
- The primary caregiver must submit proof of payment for the respite service to the Midlands Chapter office—checks and copies of receipts for payment, etc.
- Only complete reimbursement requests will be considered for payment.
- **Reimbursement is made at the Chapter Office. Checks will be mailed if receipts are accompanied by a self-addressed stamped envelope. Checks will be drafted in amounts of $200.00 or greater during the month following submission of proof of payment.**

**Please provide all of the information requested below—Reimbursement will be expedited when the application and the physician statement are completed and returned to the Chapter office. PLEASE PRINT**

Primary Caregiver Name: ____________________________________________ Age: _______

Address: ______________________________ City: __________ State: ____ Zip: ______ County: ______________

Home Phone: (____) ______-_________ Work Phone: (____) ______-_________ E-mail: ________________________

Name of Individual with dementia: ____________________________________________ Age: ______

Relationship of Individual to Primary Caregiver: ____________________________________________

Gender: ___________ Race: ___________ Physician statement is attached: yes__ no__

Annual pre-tax income ranges—*please check one*: Under $20,000___ $20-30,000___ $30-40,000 __ $40-50,000 __ Over $50,000___

The information I have provided above is accurate and I understand and agree to all of the guidelines above.

Signature of Primary Caregiver: ____________________________________________ Date: ______________