

The "Family Support Fund" Application Form FY12

Please fill out the information below and return it to:
Alzheimer's Association, 9370 Olive Blvd., St. Louis, MO 63132

New applications require a doctor's note.
Renewal applications do not require a doctor's note.

Caregiver name: _____ D.O. B. _____
Address: _____
City _____ Zipcode _____ County _____
Home phone: _____ Work phone: _____
E-Mail Address: _____
of years you have been a caregiver to your loved one: _____
African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other ___

Do you receive any services through your local Area Agency on Aging:
_____ Yes _____ No _____ I don't know

Name of person with dementia: _____
Relationship to you _____
Address, if different from caregiver's: _____
City _____ Zipcode _____ County _____
D.O. B. of person with dementia: _____
African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other ___

Medicaid: Yes ___ No ___ DCN# _____
Medicare: Yes ___ No ___ Policy # _____
Other insurance: Yes ___ No ___ Policy Name and # _____

Services for which you are in need:
_____ Adult Diapers/bedpads
_____ Nutritional supplements
_____ Durable Medical Equipment
_____ Alzheimer's medication costs not covered by insurance

Where did you find out about the Family Support Fund? _____

This request for assistance represents a genuine financial need.

Applicant's Signature

Date

Proud member of

United Way
of Greater St. Louis

