Dementia Caregiver Respite Grant Log & Survey

201 Markham Center Drive, Little Rock, AR 72205-1409
Phone: 501-224-0021 EXT 210 Fax: 501-227-6303 Email: grants@alzARK.org

AFTER GRANT FUNDS ARE SPENT. Please submit this Respite Log & Survey **no later than 90 days after your approval date.** The log and survey can be mailed, emailed, faxed, OR texted.

Care Recipient Name:_____ **Grant #:**_____
(**Care Recipient** is the patient, the person receiving the care.)

DATE OF SERVICE (on or after approval date)	# HOURS		HOURLY RATE		DAILY TOTAL	Care Provider Name (The person(s) paid/company hired to provide respite care)
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
		x	$	=	$	
TOTALS:						

Multiply # of hours by hourly rate to get the total for the day. Please submit logs in $100 or more increments.

IMPORTANT INFORMATION – PLEASE READ

IF YOU ARE NOT USING A CARE PROVIDING COMPANY, THE HIRED PROVIDER MUST BE 18 YEARS OF AGE AND OLDER AND NOT LIVING WITH THE CARE RECIPIENT. A COPY OF EVERY CARE PROVIDER'S DRIVER'S LICENSE MUST BE ATTACHED TO THE SERVICE LOG.(UNLESS AGENCY INVOICE IS ATTACHED)

PLEASE COMPLETE POST-FUNDING SURVEY ON THE 2ND PAGE →

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Post Funding Survey

Please answer and complete 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 ease of the overall grant application process: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Easy Difficult

Please rate the level ease of finding a respite provider: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Easy Difficult

Please rate the improvement of the overall stress level of the household while utilizing grant funds:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
No Improvement High Improvement

What did this grant funding allow you to accomplish? (i.e., vacation, grocery shopping, mental health, doctor's appointment, etc.) _____
_____
_____
_____
_____

Caregiver PRINTED Name:_____
(Caregiver is the person who applied for this grant.)

Caregiver Signature:_____ **Date:**_____

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