Caregiver Assistance Application

Date of Request: _____

Caregiver Information

Caregiver Name**:** _____ Age: _____ Gender: _____

Address: _____ City_____ State_____ Zip_____

County: _____ Phone: _____ Email:_____

Relationship to Care Recipient: _____ Where did you hear about us? _____

Care Recipient Information:

(Person Living with Dementia, Alzheimer's Disease, etc)

Care Recipient Name:_____ Age_____ Gender_____

Address: _____City_____ State____ Zip_____

County _____ Phone:_____

Diagnoses & Date of Diagnosis: _____

Is the Care Recipient receiving other financial support for services at this time? Yes____ No____

If yes, from whom have you received financial funds? _____

Needs Assessment

- Type of service requesting funds for:
- Respite
- Home Safety Evaluation
- Assessment by an Aging Life Care Specialist
- Care for loved one during medical emergency
- Other (Please specify) _____
  _____

Describe your need:

Please describe need for services indicated in question above. Please describe in detail your specific need for services and a break down of cost. Questions to consider: Why do you need care at this time? Why do you need a break? What has changed in your personal situation that there is a need for short term assistance?

_____

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Total Amount Requested: _____

**Please note this does not guarantee the full amount will be funded. Please include type of service, the cost for service, how many days, hours, and rate.*

Dates of Service:

Please note all funds must be used within 90 days of application approval

Service Start Date: _____ Service End Date: _____

Agency Information

Person or Agency Providing Services:_____

Address: _____

_____

Phone:_____ **Email:** _____

Office Use Only:

Date Received: _____

Approved: ☐ **Yes** ☐ **No**

Date Notified Family: _____ **Amount Approved:**_____