

Application for Respite Care Grant

Return form to:

Alzheimer's Association
2065 West El Camino Real , Suite C
Mountain View, CA 94040
Attn: Alexandra Morris (650) 962-8111
Or Deanna Bastianelli (925) 284-7942

The Alzheimer's Association offers a respite grant to families caring for a loved one with Alzheimer's disease or a related disorder. This is a one time only grant.

Please complete the following information about the Caregiver.

1. Caregiver:

Name _____

Address _____

Phone: Daytime _____ Evening _____

2. Relationship to person with dementia:

☐ Spouse ☐ Adult Child ☐ Sibling ☐ Grandchild

☐ Neighbor/friend ☐ Daughter-in-law or son-in-law

☐ Other (please explain) _____

Age of primary caregiver _____

Office Use Only:

Date application received: _____ Date sent to committee: _____

Action taken: _____

Amount provided: _____

Updated 4-3-02

3. Employment Status of the Caregiver:

- ☐ Unemployed ☐ Employed less than 25 hrs/wk ☐ Employed 25-30 hrs/wk
☐ Retired ☐ Employed 31-39 hrs/wk ☐ Employed 40+ hrs/wk

4. Caregiver's Financial Status

Total Household Monthly Income: \$ _____

Total Savings/Cash investments \$ _____

Monthly Expenses \$ _____

Please complete the following information about the person with Dementia.

5. About the Patient:

Name _____

Address (if different than above) _____

Living Arrangements (Check one):

☐ Lives alone ☐ Lives with caregiver ☐ Lives in facility

☐ Other (please explain) _____

Age of person with dementia _____

Is the patient a Veteran? _____

5A. Patient's financial status (if different from the Caregiver).

Total Household Monthly Income: \$ _____

Total Savings/Cash investments \$ _____

Monthly Expenses \$ _____

5B. Which of the following applies? Patient has:

_____ Medicare _____ MediCal _____ Private Insurance
_____ Kaiser _____ Secure Horizons _____ SSI
_____ Other

If not on MediCal has a MediCal application been submitted? ☐ Yes ☐ No

6. Medical Information:

Has the patient been diagnosed with Alzheimer's disease or a related dementia?

☐ Yes ☐ No ☐ Undergoing

Please indicate specific diagnosis:

Alzheimer's Disease _____ Multi-Infarct Dementia (Vascular Dementia) _____

Lewy Body Dementia _____ Frontotemporal Dementia _____

Parkinson's Disease with Dementia _____ Pick's Disease _____

Other (please list) _____

If diagnosed, we may need to clarify diagnosis with the doctor, therefore please include doctor name and full phone number.

Patient's Physician's name and full phone number:

Date of Diagnosis _____

Date of last visit to physician: _____

Please describe the patient's primary symptoms: _____

7. Respite Service Information:

During the past year, what types of paid respite care services have you used for the patient?

(Check all that apply)

☐ None ☐ Personal care (e.g., Bathing) - How often? _____

☐ Adult Day Care - How often? _____ ☐ Housekeeping How often? _____

☐ In-home companion - How often? _____

☐ Short Term residential care - How often? _____

☐ In-home nursing care - How often? _____

☐ Other (please describe) _____

Which one of the above respite services would you like to utilize?

8. Referral Information:

How did you hear about the respite care grant program? (Check all that apply)

- ☐ Family/friends
 ☐ Physician
☐ Day Care Facility
 ☐ Senior Citizens Center
☐ Home care agency
 ☐ Residential Care Home/Nursing Home
☐ Alzheimer's Association: Helpline_____ Support Group_____ Newsletter _____
☐ Hospital/Diagnostic Center (please specify)_____
☐ Family Caregiver Alliance
 ☐ Other (please describe)_____

9. Please describe your current situation and why you are seeking assistance for respite services at this time. _____

[illegible]

Name of person completing form: _____ Date _____

Phone: _____

If with an agency, please attach business card.

Additional Information:

The following information is used for statistical purposes.

The race/ethnicity of the **Caregiver**:

☐ Caucasian/white

☐ African American/black

☐ American Indian

☐ Latino/Hispanic

☐ Asian/Pacific Islander

☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Cambodian

☐ Hawaiian ☐ Vietnamese ☐ Laotian ☐ Samoan

☐ Guamanian ☐ Korean ☐ Japanese ☐ Other (Name) _____

The race/ethnicity of the **Person with Dementia**:

☐ Caucasian/white

☐ African American/black

☐ American Indian

☐ Latino/Hispanic

☐ Asian/Pacific Islander

☐ Chinese ☐ Asian Indian ☐ Filipino ☐ Cambodian

☐ Hawaiian ☐ Vietnamese ☐ Laotian ☐ Samoan

☐ Guamanian ☐ Korean ☐ Japanese ☐ Other (Name) _____

This form will be removed/separated from the application.