







**FAMILY CAREGIVER INFORMATION**

Caregiver's Name: \_\_\_\_\_

Gender:  Male  Female

Marital Status:  Never married  Married  Widowed  Separated  Divorced

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO/DAY/YR

Social Security Number:

XXX-XX-\_\_\_\_\_  
(Last four digits only)

Address including PO Box's: \_\_\_\_\_  
(Street and PO Box) City/ST/Zip  
\_\_\_\_\_

E-mail address: \_\_\_\_\_

Telephone – Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Caregiver's Relationship to Care Recipient:**

Daughter  Daughter-in-law  Wife  Husband  Son  Son-in-law  
 Grandparent  Non-Relative  Other Relative: \_\_\_\_\_

Ethnicity:  Not Hispanic/Latino  Hispanic/Latino  Unknown

Race:  Non-Minority/White  Native American/Alaskan Native  Native Hawaiian/Pacific Islander  
 Asian  Black/African American  Hispanic/white  Other: \_\_\_\_\_

***If an individual is authorized to act as legal representative for the care recipient, please provide documentation of such power (e.g. power of attorney, appointment of conservatorship through Probate Court.)***

How did you hear about the Program? (Check all that apply)

Newspaper  From a Friend  Area Agency on Aging  TV  Radio  
 Internet  Other\* (please describe) \_\_\_\_\_

**\* If agency, please write the agency name and number of person making referral.**

**Income / Asset Statement**

(This information applies to both programs)

Please list care recipient's sources of income. The following are considered income: Social Security (minus Medicare Part B and Part D Premiums), Supplemental Security, Railroad Retirement Income, Pensions, Wages, Interest and Dividends, Net Rental Income, Veteran's Benefits, and any other payments received on a one-time recurring basis.

Please indicate liquid assets of the care recipient and his or her spouse. Liquid assets are defined as an asset that can be converted into cash within twenty working days. List account balances for all liquid assets, including checking accounts, certificates of deposit, savings accounts, individual retirement accounts, stocks, bonds, and all life insurance policies. Include all accounts in the applicant's name as well as those in both the applicant's and their spouse's name. If the income is from a jointly held asset, indicate so by writing "yes" in the appropriate column.

	<b><u>Monthly Amount</u></b>	
	Care Recipient	Spouse
1. Social Security (minus Medicare Premiums), SSI, and Railroad Retirement	\$ _____	_____ (*Optional)
2. Pensions, retirement income, annuities	\$ _____	_____ (*Optional)
3. Veteran's Benefits	\$ _____	_____ (*Optional)
4. Interest and Dividends	\$ _____	_____ (joint?) with whom?
5. Other income (wages, net rental income, non-taxable income)	\$ _____	_____ (joint?) with whom?
<b>TOTAL AMOUNT OF INCOME</b>	\$ _____ (Care recipient)	_____ (joint?) with whom?

\*Spousal income information is used to identify other sources of support and is not a determining factor of eligibility.

<b><u>Liquid Assets</u></b>	<b><u>Amount</u></b>	<b><u>Joint?</u></b>
_____	\$ _____	_____ with whom?
_____	\$ _____	_____ with whom?
_____	\$ _____	_____ with whom?
_____	\$ _____	_____ with whom?
<b>TOTAL AMOUNT OF LIQUID ASSETS</b>	\$ _____	_____ with whom?

**CERTIFICATION AND AUTHORIZATION**  
(This information applies to both programs)

I certify that the information on this form is true, accurate, and complete.

I further authorize any health care provider to release any medical records to ensure that appropriate services are provided by the program.

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SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT

DATE

## **COST SHARE AGREEMENT**

(For the National Family Caregiver Support Program only)

I am applying for services for: \_\_\_\_\_  
Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I may be asked to make a cost share contribution for the cost of the services received. This determination is based upon a sliding fee scale and the individual's income as compared to the most recent US Poverty Guidelines (see attachment to this application for the scale). The Area Agency on Aging shall determine whether the participant qualifies to participate in cost-sharing for this program. The cost share shall be used to replenish program funds and therefore assist other caregiving families, and shall be made directly to North Central Area Agency on Aging (NCAAA).

\_\_\_\_\_  
Signature of Caregiver

\_\_\_\_\_  
Date

I understand that if I have questions I can call:



**NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)**

**151 NEW PARK AVE, BOX 75, HARTFORD, CT 06106**

**PHONE: 860-724-6443 or 1-800-994-9422**

**FAX: 860-251-6107**

**WEB: [www.ncaaact.org](http://www.ncaaact.org)**

**EMAIL: [info@ncaaact.org](mailto:info@ncaaact.org)**

## **CO-PAYMENT AGREEMENT**

(For the Connecticut Statewide Respite Care Program only)

I am applying for services for: \_\_\_\_\_  
Name of Care Recipient

I understand that as the caregiver and as the person requesting respite services, I will be asked to make a co-payment for a portion of the cost of the services received.

The Statewide Respite Care Program requires that participants pay a 20% co-payment of the cost of the services received. This co-payment may be waived based upon demonstrated financial hardship and is determined by the Agency. I understand that if I have an emergency that makes me unable to pay my fee that I must contact the Area Agency as soon as possible, and a special payment schedule may be arranged.

I understand that the amount of my payment could change if the services I receive are modified. If this occurs, I understand that I will be notified.

The co-payment shall be used to replenish program funds and therefore assist other caregiving families. The co-payment shall be made directly to North Central Area Agency on Aging (NCAAA).

\_\_\_\_\_  
Signature of Caregiver Date

I understand that if I have questions I can call:



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**\*PHYSICIAN STATEMENT**

(\*A physician’s statement must be obtained for care recipients under the age of 60 who have irreversible or deteriorating dementia or is seeking help only from the Connecticut Statewide Respite Care program.)

An application has been made to North Central Area Agency on Aging (NCAAA) for the individual named below. In order to evaluate the application, information is needed regarding the disability, health and medical problems, and the level of care of the individual. Please answer the following questions.

**Patient’s Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

*For Physician use only:*

**Does this patient have irreversible and deteriorating dementia?**

**Yes**                       **No**

\_\_\_\_\_  
**SIGNATURE OF PHYSICIAN** **DATE**

Name of Physician (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Please return form to:



**PERMISSION FOR RELEASE OF MEDICAL INFORMATION**

**CAREGIVER OR AUTHORIZED AGENT: Please complete this page and send it, along with the physician's statement, to your physician.**

I agree to the release of medical information on:

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Name of Patient

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Address

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Phone

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Date of Birth

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**SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT**

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**DATE**

**Please return this form to:**



**NORTH CENTRAL AREA AGENCY ON AGING (NCAAA)  
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