Alzheimer's
SERVICES
of the Capital Area

Caregiver Respite Reimbursement Program

Enrollment Application

Care Recipient Information (Patient)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parish: _____ Home Phone: _____

SS#: _____ D.O.B.: _____ Race: _____

Diagnosis: _____

Physician: _____

Physician Phone: _____ Fax: _____

Family Caregiver Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parish: _____ Home Phone: _____

Home Phone: _____ Daytime Phone: _____

Email address: _____

SS#: _____ D.O.B.: _____ Race: _____

Relationship to Patient: _____

Please attach physician's statement verifying diagnosis.

*Alzheimer's Services, 3772 North Blvd., Baton Rouge, LA 70806 * (225) 334-7494*

For office use only

Date application received: _____ Interview date: _____ Staff initials: _____

Revised Oct/2009

Alzheimer's
SERVICES
of the Capital Area

Caregiver Respite Reimbursement Program
Guidelines

Definition:
Respite is taking a short break from day-to-day caregiving responsibilities. It can be provided in or out of the home setting as desired by the family caregiver, but *does not include permanent residence in a care facility*. Respite care may include a sitter or home health aide providing care and supervision in the home or the recipient/patient may attend an adult day program outside the home.

Eligibility:

- **The care recipient must have a diagnosis of Alzheimer's disease or another form of dementia.** The individual's physician or health care provider must confirm this in writing. A letter from the physician on his/her stationary, prescription pad, or a copy of a completed and signed 90L form or medical assessment form may provide this confirmation.
- **The dementia patient must reside in either his or her own home or apartment or that of a friend or relative who is serving as the primary caregiver.** Those residing in long term care or assisted living facilities, or group homes will not be eligible.
- **The sitter or home health aide may not be a relative or someone who is residing in the home with the recipient/patient.**
- **The recipient/patient must reside in the ten-parish service area of Alzheimer's Services of the Capital Area.** This area includes the following parishes: Ascension, Assumption, East and West Baton Rouge, East and West Feliciana, Iberville, Livingston, Pointe Coupee, and St. Helena.

Enrollment Process:
Caregivers must meet the criteria provided above as well as complete an application process and be pre-approved prior to service use. The application process may be completed in the caregiver's home if he/she is unable to leave the person with dementia. The application process includes completion of the Caregiver Burden Interview and review and signing of the program guidelines. The primary caregiver is responsible for selecting the sitter, home health aide, or adult day program. Alzheimer's Services of the Capital Area is not responsible for the quality or provision of care but will provide caregivers with information and referral assistance.

Once enrolled, the caregiver may submit receipts for respite care to Alzheimer's Services for reimbursement. **The receipt must include: Sitters name, phone number and address along with their signature, and caregiver's signature. This information may be used for auditing purposes**. Participants **may** receive up to *$100 per month, for a maximum of $600 in 12 months*. All receipts must be submitted within 30 days of service; due to funding regulations we will not be able to reimburse receipts over 30 days old. All receipts should be submitted by the **10th of each month**. Alzheimer's Services will issue reimbursement checks once a month and they will be mailed out no later than the 15th of the following month. *Alzheimer's Services of the Capital Area does not guarantee any amount for reimbursement. Funds are distributed on a first come, first served basis and are based on the Caregiver Respite Program Fund balance.* Toward the end of the funding period Respite Program Coordinator will administer a Satisfaction Survey, to gage the helpfulness of the program; this may be completed over the phone, in person or by mail.

Re-enrollment is not guaranteed and is based on funding availability and participants may be subject to a waiting period. Caregivers must meet the eligibility criteria and complete the enrollment process again. Caregivers who have never utilized the Caregiver Respite Program may have first priority.

For more information, contact Alzheimer's Services of the Capital Area, 3772 North Boulevard, Baton Rouge, Louisiana, 70806, 225-334-7494 (Baton Rouge) or 1-800-548-1211, FAX 225-387-3664, www. BRhope.com.

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

RESPITE CARE REIMBURSEMENT SERVICES FUNDING GUIDELINES

Alzheimer's Services is pleased to be able to supplement Respite Care Services with grant funding. Please choose *one* of the programs listed to receive Respite Care Services Funding:

☐ Charlie's Place Respite Center

The Charlie's Place fees: (effective June 1, 2013)

1 day per week = $285/month ($235 after respite credit applied)

2 days per week = $570/month ($520 after respite credit applied)

In order to serve more caregivers who may need this financial assistance, please consider your need before enrolling in this program.

☐ Caregiver Respite Reimbursement Program

The following guidelines apply:

- The grant benefit will be a maximum *gift* of **$600 in a 12 month period.**
- If you choose the Charlie's Place option, the supplement will be automatically deducted on the **Charlie's Place** invoice accordingly with the monthly fee. Maximum $600 total benefit.
- If you choose the Caregiver Respite Reimbursement Program option, the benefit is **$100** per month (maximum $600 total benefit)
- Recipients have 12 months to use the $600 gift
- Recipients must have a physicians diagnosis of dementia to participate
- The recipient must reside within our 10 parish service area
- Re-enrollment is based on a waiting list; those who have never participated in the program have priority on the list
- This program is based on funding availability, ***no amount of funding is guaranteed***
- This form must be signed and filed with Alzheimer's Services before any Respite Care Services funding can begin

I understand and agree with the guidelines of the Alzheimer's Services Respite Care Services Funding Program.

_____ _____

Signature of Caregiver to receive reimbursement Date

_____

Name of Memory Impaired Individual

Reviewed by: _____

Date: _____

Alzheimer's SERVICES of the Capital Area

Charlie's PLACE

Physician's Statement

Thank you for completing this form for your patient who has applied for the Respite Reimbursement Program. For more information, contact Alzheimer's Services (225) 334-7494.

Client's Name: _____ DOB: _____

Physician's Name: _____ Fax Number: _____

Diagnosis (check one):

☐Dementia
☐Alzheimer's disease
☐Pick's disease
☐Mild Cognitive Impairment
☐Lewy Bodies
☐Vascular dementia
☐Frontal Temporal Lobe dementia
☐Parkinson's
☐Other related disorder: _____

Allergies: _____

Diet: _____

_____ _____

Physician's Signature Date

For Office Use Only **Total Score _____**

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM
INTAKE ASSESSMENT FORM

SECTION A: AGENCY/ORGANIZATION INFORMATION

Date of Request or Referral: _____ (Month/Day/Year) **Method of Contact**: ❒ telephone ❒ face-to-face ❒ other

Assessor Name: _____ **Agency Name:** _____

SECTION B: INITIAL SCREENING AND INTAKE

PERSON PROVIDING ANSWERS AND INFORMATION FOR ASSESSMENT:

❒ Caregiver ❒ Friend/neighbor ❒ Legal guardian or surrogate decision-maker
❒ Family member ❒ Other professional (e.g. care manager)

PRIMARY LANGUAGE:

❒ English ❒ Spanish ❒ French ❒ Other _____

QUALIFYING INDIVIDUAL (Person receiving care):

Name: _____ Address:_____

State: _____ Zip Code: _____ Parish: _____ Phone: _____

Social Security Number: _____ Date of Birth: _____

Caregiver by Relationship ❒ Husband ❒ Wife ❒ Son/Son-in-law ❒ Daughter/Daughter-in-law
❒ Other Relative ❒ Non-Relative

SECTION C: CAREGIVER INFORMATION

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Louisiana Identification Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name: _____ **First Name**: _____ **MI**: _____

Address:_____ **Apt. #**: _____ **Parish**: _____

State: _____ **Zip Code**: _____ **Telephone (Home)**: _____ **Work**: _____

DOB: _____ (Month/Day/Year) **Rural/Isolated**: ❒ Yes ❒ No

Gender: ❒ Male ❒ Female

Race: ❒ White (Alone)
❒ Black or African American (Alone)
❒ American Indian/Alaskan Native (Alone)
❒ Native Hawaiian/Other Pacific Islander
❒ Asian (Alone)
❒ Declined to Respond
❒ Other _____

Marital Status: ❒ Never Married
❒ Married
❒ Partner/Significant Other
❒ Widowed
❒ Separated
❒ Divorced

Ethnicity: ❒Hispanic/Latino ❒Not Hispanic/Latino

For Office Use Only	Total Score _____

NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM
INTAKE ASSESSMENT FORM (CONTINUED)

Name of Client (Caregiver): _____ ID #: _____

SECTION D: Priority Status (check all that apply)
☐ Client is an older individual in greatest economic need ☐ Client is an older individual in greatest social need ☐ Client is an older individual providing care and support to person who has a developmental disability
Eligibility for Respite Care, Personal Care, Material Aid and Sitter Service (check all that apply – at least one must apply to be eligible):
☐ The qualifying individual is unable to perform at least two of the following activities without substantial human assistance, including verbal reminding, physical cueing, or supervision: bathing; dressing; toileting; transferring; walking: eating. ☐ The qualifying individual has a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

Describe the type of assistance needed {continue on supplemental sheet(s)}:
Directions to Home of Qualifying Individual {continue on supplemental sheet(s)}:

I have received a copy of the grievance procedure and contribution policy.

_____ _____

Date **Signature of Caregiver**

_____ _____

Date **Signature of Intake Worker**

Name of Client (Caregiver): _____ ID#_____

FAMILY CAREGIVER SUPPORT PROGRAM SCORE SHEET

1. The caregiver's income level is at or below the federal poverty line No=0 Yes=1	
2. The caregiver has "greatest social need." No=0 Yes=1	
3. The caregiver is 60 years of age or older and providing care and support to person that has a developmental disability. No=0 Yes=1	
4. Age of Caregiver: Under 60=0 60-74 years of age=1 75 years of age or older=2	
5. How does the caregiver rate his/her overall health? Good=0 Fair=1 Poor=2	
6. For how many qualifying individuals is this caregiver the primary caregiver? (one point for each qualifying individual)	
7. How many hours of direct care on average each day does the caregiver provide to the qualifying individual? 8 hours or less=0 9-16 hours=1 17-24 hours=2	
8. Is the caregiver employed? No=0 Part-time=1 Full-time (35 or more hours a week)=2	
9. With how many of the following activities of daily living does the caregiver provide assistance to the qualifying individual? (one point for each – circle all that apply) BATHING DRESSING TOILETING TRANSFERRING WALKING EATING	
10. Does the qualifying individual receive assistance with any of the activities in question 9 from any other source? Yes=0 No=1	
11. *Caregiver Stress Level: Little/No Stress=0 Mild/Moderate=1 Moderate/Severe=2 Severe=3	
TOTAL SCORE	

* Use the "Caregiver Stress Interview" score to compute number 11

Then put the TOTAL SCORE on the top right corner of the NFCSP Assessment

Name of Client (Caregiver): _____ ID# _____

CAREGIVER STRESS INTERVIEW

Read to Caregiver: The following is a list of statements which reflect how people sometimes feel when taking care of another person. After each statement, indicate how often you feel that way: never, rarely, sometimes, quite frequently, or nearly always. There are no right or wrong answers.

QUESTION	Never 0	Rarely 1	Sometimes 2	Quite Frequently 3	Nearly Always 4	Score
1. Do you feel that your relative asks for more help than he/she needs?						
2. Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?						
3. Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?						
4. Do you feel embarrassed over your relative's behavior?						
5. Do you feel angry when you are around your relative?						
6. Do you feel that your relative currently affects your relationship with other family members or friends in a negative way?						
7. Are you afraid of what the future holds for your relative?						
8. Do you feel your relative is dependent upon you?						
9. Do you feel strained when you are around your relative?						
10. Do you feel your health has suffered because of your involvement with your relative?						
11. Do you feel that you don't have as much privacy as you would like because of your relative?						

Continued next page

Caregiver Stress Interview Continued

Name of Client (Caregiver)_____ ID#_____

QUESTION	Never 0	Rarely 1	Sometimes 2	Quite Frequently 3	Nearly Always 4	Score
12. Do you feel that your social life has suffered because you are caring for your relative?						
13. Do you feel uncomfortable about having friends visit you because you are caring for your relative?						
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?						
15. Do you feel that you don't have enough money to care for your relative in addition to the rest of your expenses?						
16. Do you feel that you will be unable to take care of your relative much longer?						
17. Do you feel you have lost control of your life since your relative's illness?						
18. Do you wish you could just leave the care of your relative to someone else?						
19. Do you feel uncertain about what to do about your relative?						
20. Do you feel you should be doing more for your relative?						
21. Do you feel you could do a better job in caring for your relative?						
22. Overall, do you feel burdened caring for your relative?						
* CAREGIVERS STRESS LEVEL:						

* The caregiver STRESS LEVEL is calculated by questions 1 -22 and will be used for pg 1 of the Caregiver Support Program Score Sheet: 0 – 20 = Little/No Stress 21 – 40 = Mild/Moderate Stress
41- 60 = Moderate/Severe Stress 61 – 88 = Severe Stress