SUBMITTING YOUR APPLICATION

Applications can be mail, email or drop off at the office location.*

April Green, Family Caregiver Support Program Advocate

Santee-Lynches Regional Council of Governments (AAA)

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**An interview will be conducted after we have received your application.*

CAREGIVER PARTICIPATION AGREEMENT

Caregiver's **or** Grandparent's Name: _____
(if applying for SRC program)
Care Receiver **or** Grandchild(ren) Name(s): _____

I certify that I am responsible for the care of the Care Receiver/Grandchild(ren), who lives in the Santee-Lynches Region (*Clarendon, Kershaw, Lee and Sumter Counties*), and I am the primary responsible person providing or directing his/her/their care.

1. I certify that all information provided to the Santee-Lynches Area Agency on Aging FCSP staff is correct to the best of my knowledge.
2. I understand that no one who lives in the household may receive FCSP funds or respite funds for providing services. I further understand that if I break this rule or provide incorrect or fraudulent information, or the misuse of funds, I may be permanently terminated from this program.
3. I understand that my participation in cost sharing is voluntary. My level of participation depends on my willingness and ability to share in the cost of the service.
4. I pledge to ***promptly*** (within 7 working days) notify the Caregiver Advocate of changes in situation (such as major health changes, hospitalization, change of address or phone number, change in condition of either the Care Receiver, grandchildren I am responsible for, or myself.
5. I am willing to abide by the guidelines of the FCSP, including making choices of providers and resources, following the required hiring procedures, completing monthly forms and sending them in for reimbursement *(within 30 days for date of service or purchase).*
6. I understand that the maximum amount of funds received in one calendar year will vary depending on available funding.
7. I understand that where applicable, submitted receipts must be approved by the Family Caregiver Support Coordinator prior to reimbursement. Failure to abide by program guidelines will disqualify me from reimbursement. I have been informed of my rights and responsibilities as a client in the FCSP.
8. I understand that the Santee-Lynches Area Agency on Aging FCSP and other respite programs is a Caregiver directed program and I will be requested to participate in interviews and/or surveys to measure client satisfaction and effectiveness of the program. I also understand that if I choose not to respond it will not to respond it will not affect my eligibility for the program and its benefits.
9. I understand that the Family Caregiver Coordinator or other Santee-Lynches staff reserve the right to conduct unannounced visit to validate eligibility.

Signature: _____ Date: _____
(Caregiver)

CONSENT TO RELEASE INFORMATION

(Family Caregiver)

Last Name: _____

First Name: _____

Middle Name: _____

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Lieutenant Governor's Office on Aging and the U.S. Federal Government. The information provided will be kept confidential and guarded against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for clients (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client).

My information may be used to arrange for these services: **Yes** ☐ **No** ☐

Some of the data asked for is required by either the South Carolina Lieutenant Governor's Office of Aging and/or the U.S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

My information may be shared with the entity(ies) funding my service(s): **Yes** ☐ **No** ☐

Client Signature: _____ Date: _____

If read to client, by whom: _____ Date: _____

Relation: _____

Assessor Signature: _____ Date: _____

SERVICES REQUESTED

CHECK ALL THAT APPLY

- ☐ Respite care
- ☐ Respite care for an Alzheimer's or dementia patient
- ☐ Nutritional supplements *(Boost, Ensure, Jevity, etc.)**
  **(Medical Documentation Required)*
- ☐ Incontinence supplies *(Depends, Wipes, etc.)*
- ☐ Assistive technology *(Shower chair, walker, etc.)*
- ☐ School related expenses/ Afterschool programs *(For Seniors Raising Children)*

ALZHEIMER'S DISEASE AND RELATED DISORDERS

PHYSICIAN DIAGNOSIS STATEMENT

To be completed and signed by patient's physician

Qualifications for the Respite Assistance Program depends on the patient's diagnosis. This respite program serves patients with Alzheimer's disease and related dementias.

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____

CAREGIVER OR RESPONSIBLE FAMILY MEMBER

Name: _____

Telephone: _____

PHYSICIAN INFORMATION

Name: _____

Signature: _____

Telephone: _____

Date: _____

PLEASE CHECK ONE OF THE FOLLOWING:

☐ Alzheimer's Disease

☐ Creutzfeldt-Jakob Disease

☐ Vascular Dementia

☐ Lewy-Body Dementia

☐ Huntington's Disease

☐ Pick's Disease

☐ Parkinson's Disease

☐ Mixed Dementia

Caregiver Assessment	AIM ID	Interviewer	Date

Introductory Information

First Name	M.I.	Last Name	Are you a Paid Caregiver?
Physical Address			Apt
City	State	Zip	County
Mailing Address (if different)			
Primary Phone	Secondary Phone		Internet ☐ Yes ☐ No
Age	DOB mm/dd/yyyy	Email	
Type of Visit: ☐ Home ☐ Phone		Client Status: ☐ New ☐ Returning	

Demographics

Gender
☐ Female ☐ Male ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latinx ☐ Declined ☐ Not Hispanic or Latinx

Marital Status
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Domestic Partner/Civil Union

Race
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Asian/Asian American ☐ White
☐ Black/African American ☐ Declined
☐ Other _____

Number in Household _____

Monthly Household Income
☐ Under $1,074 ☐ $1,074-1,452 ☐ $1,453-1,830 ☐ $1,831-2,208 ☐ $2,209-2,589 ☐ $2,590+

Languages Known

Does the CG speak a language other than English at home? ☐ Yes ☐ No

If Yes, Specify: _____ Limited English Proficiency: ☐ Yes ☐ No

Caregiver's Relationship to Care Recipient

☐ Husband ☐ Son/Son-in-law ☐ Sister ☐ Other Relative
☐ Wife ☐ Daughter/Daughter-in-law ☐ Brother ☐ Non-Relative
☐ Domestic Partner, including civil union ☐ Grandparent ☐ Parent

Care Recipient Condtion

Does the care receiver have a condition that causes limitations in activities? ☐ Yes ☐ No

Condition
☐ ADRD ☐ Intellectual Disability ☐ Physical Condition ☐ Cognitive/Behavior Condition
☐ Wandering ☐ Total Care ☐ Other ☐ None

Has the care receiver been diagnosed, by a physician, to have Alzheimer's or a related dementia? ☐ Yes ☐ No

Caregiver's Time

Do you live with the care recipient? ☐ Yes ☐ No Does the care recipient live alone? ☐ Yes ☐ No

If not, how long does it take to get to their residence (or where you provide care)? _____ (hh:mm)

How long have you been providing care for this person? _____ (Total Years/Partial Year)

How often do you provide care for this person? _____ (Average hours per week)

Do you maintain other employment? ☐ Full Time ☐ Part Time ☐ Declined

Is there anyone else that provides care for this person? ☐ Yes ☐ No

Is there any other program that has provided respite services within the last twelve (12) months? ☐ Yes ☐ No

Caregiver Assessment	Interviewer	Date

General Health Statement

How do you rate your health? ☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor ☐ Declined

UCLA Three-Item Loneliness Scale

How often do you feel that you lack companionship?	☐ Hardly Ever	☐ Some of the Time	☐ Often
How often do you feel left out?	☐ Hardly Ever	☐ Some of the Time	☐ Often
How often do you feel isolated from others?	☐ Hardly Ever	☐ Some of the Time	☐ Often

Bakas Caregiver Outcome Scale

As A Result of Providing Care for the Patient:	Changed for the worst.			Did not change	Changed for the best.		
1. My self esteem	-3	-2	-1	0	+1	+2	+3
2. My physical health	-3	-2	-1	0	+1	+2	+3
3. My time for family activities	-3	-2	-1	0	+1	+2	+3
4. My ability to cope with stress	-3	-2	-1	0	+1	+2	+3
5. My relationship with friends	-3	-2	-1	0	+1	+2	+3
6. My future outlook	-3	-2	-1	0	+1	+2	+3
7. My ability to pay the bills	-3	-2	-1	0	+1	+2	+3
8. My emotional well-being	-3	-2	-1	0	+1	+2	+3
9. My time for social activities with friends	-3	-2	-1	0	+1	+2	+3
10. My relationship with my family.	-3	-2	-1	0	+1	+2	+3
11. My ability to buy necessities.	-3	-2	-1	0	+1	+2	+3
12. My relationship with the patient.	-3	-2	-1	0	+1	+2	+3
13. In general, how has your life changed as a result of taking care of the patient?	-3	-2	-1	0	+1	+2	+3

Caregiving Overview

How many dependent adults do you care for, including this care receiver? # _____

How many of these dependent adults have a dignosed disability? # _____

How many dependent children do you care for, under the age 18? # _____

How many of these dependent children have a dignosed disability? # _____

Care Recipient Information

First Name	M.I.	Last Name	
Physical Address			Apt
City	State	Zip	County
Primary Phone	Secondary Phone		Internet ☐ Yes ☐ No
Age	DOB mm/dd/yyyy	Email	

Caregiver Assessment	Interviewer	Date

Care Recipient Demographics

Gender
☐ Female ☐ Male ☐ Other ☐ Declined

Ethnicity ☐ Hispanic or Latinx ☐ Declined ☐ Not Hispanic or Latinx

Marital Status
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Domestic Partner/Civil Union

Race
☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander
☐ Asian/Asian American ☐ White
☐ Black/African American ☐ Declined
☐ Other _____

Military Service
☐ Retired Military ☐ History of Military Service ☐ Never Served ☐ Spouse/Widow(er) of Veteran ☐ Declined

Services Received from Other Sources

☐ Aid/Attendance (VA) ☐ CLTC ☐ DMH ☐ Hospice ☐ SNAP ☐ Informal Support
☐ APS/VAGAL ☐ DDSN ☐ Home Health ☐ Medicaid ☐ AAA Services ☐ LTC Insurance

Activities of Daily Living - The Katz Scale

	Independence - **NO** supervision, direction, or personal assistance		**Dependence** - **WITH** supervision, direction, personal assistance or total care	
Bathing		Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.		Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
Dressing		Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.		Needs help with dressing self or needs to be completely dressed.
Toileting		Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.		Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
Transferring		Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.		Needs help in moving from bed to chair or requires a complete transfer.
Continence		Exercises complete self control over urination and defecation.		Is partially or totally incontinent of bowel or bladder.
Feeding		Gets food from plate into mouth without help. Preparation of food may be done by another person.		Needs partial or total help with feeding or requires parenteral feeding.
Walking		Is independent in their walking and mobility.		Needs assistance in walking and mobility.

Instrumental Activities of Daily Living Assistance Needed

☐ Ability to Use Telephone ☐ Food Preparation ☐ Laundry ☐ Responsibility for Own Medications
☐ Shopping ☐ Housekeeping ☐ Mode of Transportation ☐ Ability to Handle Finances

Fall Risk (STEADI)

Does the care recipient feel unsteady when standing or walking?	☐ Yes	☐ No
Has the care recipient expressed any worry about falling?	☐ Yes	☐ No
Has the care recipient fallen in the past year?	☐ Yes	☐ No
If YES, How many times? Were they injured?	# of times _____	Injured:

Caregiver Assessment	Interviewer	Date

Caregiver's Interest/Referrals

AAA Caregiver Services

☐ Education/Training ☐ Respite ☐ Counseling ☐ Supplemental Services ☐ Support Groups ☐ Seniors Raising Children

Other AAA Services

☐ III - B ☐ III - C ☐ SHIP

Community Services

☐ CLTC ☐ Adult Day Care ☐ NHP ☐ VA ☐ Other/Etc

Notes