CareBreaks

"Providing a respite break for caregivers caring for loved ones of any age."

Application

Section 1

Care Recipient Information

These questions are about the person who is cared for.

A.

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female

Is the care recipient a veteran? ☐ Yes ☐ No

Is or was the care recipient married to a veteran? ☐ Yes ☐ No

Primary language spoken by the care recipient:

☐ English ☐ Portuguese
☐ Spanish ☐ Other_____

Medical Diagnosis/Disability (*Please Specify)*

_____

_____

B. Completing the following **care recipient's** information does **not** affect eligibility for services. This information is for statistical purposes only.

Care Recipient Demographics

Marital Status (if over 18)
- ☐ Married
- ☐ Widowed
- ☐ Never Married
- ☐ Divorced
- ☐ Separated

Living Arrangement
- ☐ Alone
- ☐ With spouse only
- ☐ With spouse & other relatives
- ☐ With other relatives
- ☐ With non-relative
- ☐ Living with parent

Relationship to caregiver
- ☐ Wife
- ☐ Husband
- ☐ Daughter(-in-law)
- ☐ Son (-in-law)
- ☐ Mother
- ☐ Father
- ☐ Other relative
- ☐ Non-relative
- ☐ Other _____

Employment
- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Other_____

Annual Household Income
- ☐ Under $8,000
- ☐ $8,000 - $11,999
- ☐ $12,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ Over $40,000

Education
- ☐ 8th Grade or less
- ☐ High School Diploma
- ☐ Some College
- ☐ Specialized Training
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Other_____

Race/Ethnicity (check all that apply)
- ☐ White, non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other_____

Section 2

Caregiver Information

*These questions are about the **caregiver** - The person who does the caring.*

A.

Last Name: _____ First Name: _____

Address: _____ Apt: _____
*If caregiver does not live with care recipient please provide proof of address (see Instructions)

City: _____ State: _____ Zip: _____

Telephone: _____ Cell phone: _____

Email: _____ Date of Birth: _____/_____/_____

Gender: □ Male □ Female Are you a veteran? □ Yes □ No

Number of hours the caregiver spends providing care in an average week: _____

What will this break allow you to do: _____

_____

How did you learn about CareBreaks? _____

Type of services I'm interested in for the care recipient:
□ In-home hourly care
□ Temporary overnight care
□ Combination of services
□ Adult day care
□ Other_____
□ I need more information about choices:_____

Are you receiving any services now?
□ Yes – If yes, what service(s)?_____ Agency/Program_____
□ No

Regular Care Provided by Caregiver

B. As the caregiver for this individual, I regularly (daily/weekly) assist him/her with the following: (check all that apply)

Basic Activities of Daily Living

- ☐ Personal hygiene bathing/grooming
- ☐ Feeding
- ☐ Dressing and undressing
- ☐ Toileting
- ☐ Bowel and bladder management – including incontinence care
- ☐ Transferring/walking (moving from bed to wheelchair, getting on and off toilet)

Inability of Care Recipient to perform

- ☐ Housework
- ☐ Meal preparation
- ☐ Medication management
- ☐ Shopping
- ☐ Money management
- ☐ Transportation
- ☐ Using the telephone and other communication devises

Special Health Care

- ☐ Medical equipment (oxygen, feeding tube, respiratory equipment, etc.)
- ☐ Medication (prescribed, ongoing)
- ☐ Nursing assistance (visits regularly)
- ☐ Diabetes (insulin dependent/special diet)
- ☐ Use of wheelchair, cane, crutches, braces, or walker
- ☐ Incontinence - How often? _____
- ☐ Other specialized care needs_____

Care Recipient has difficulty

- ☐ Seeing
- ☐ Communicating
- ☐ Hearing
- ☐ Comprehending

The Care Recipient has the following specific conditions

- ☐ Aggressiveness
- ☐ Withdrawn
- ☐ Acting out/impulsive
- ☐ Alzheimer's or dementia
- ☐ Seizures – Type_____ Date of last Seizure_____

Homebound (cannot leave home without considerable assistance)

- ☐ Yes ☐ No

Caregiver Demographics

C. Completing the following caregiver information does not affect eligibility for service. This information is for statistical purposes only.

Marital Status (if over 18)

- ☐ Married
- ☐ Widowed
- ☐ Never Married
- ☐ Divorced
- ☐ Separated

Relationship to Care Recipient

- ☐ Wife
- ☐ Husband
- ☐ Daughter(-in-law)
- ☐ Son (-in-law)
- ☐ Mother
- ☐ Father
- ☐ Non-relative
- ☐ Other relative
- ☐ Other

Employment

- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Unemployed
- ☐ Other_____

Annual Household Income

- ☐ $8,000 - $11,999
- ☐ $12,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ Over $40,000

Education

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- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other_____

Income Information

In order to determine our level of cost sharing please…
Complete Section A if you are caring for someone 18 or older
OR
Complete Section B if you are caring for someone under 18 years old

In the appropriate box list **all** Income – Taxable and non-taxable
(Married couples must report their combined income)

Please check one: Income below, is from the past **Year___** or **90 Days___**

Section A. ***Care Recipient Income Information if the Care Recipient is 18 or older***

Federally Adjusted Gross Income (As reported annually to the IRS)	**$** *
Social Security (If not reported on tax return)	**$** *
Other Income (If not reported on tax return)	**$** *

Section B. *Caregiver Income Information if the care recipient is under 18 years old*

Number of dependents living in household (including yourself/spouse):_____

Federally Adjusted Gross Income (As reported annually to the IRS)	**$** *
Social Security (If not reported on tax return)	**$** *
Other Income (If not reported on tax return)	**$** *

***attach documentation**

Medical Expenses

No matter which of the above Income Information sections you filled out, please include information about your medical expenses, if applicable. By submitting your Medical expenses, we may be able to reduce your co-pay.

Medical Expenses – Please enter the amount medical expenses paid over the past (choose one)

Year $_____ OR 90 Days_____

Please refer to the *Medical Expenses* portion of the *Application Instructions* for details on eligible medical expenses.

Your application is complete if you have included the following

- ✓ Proof of primary caregiver's address
- ✓ Proof of Care Recipient's age
- ✓ Income verification
- ✓ Medical expense verification (if any)

Please send completed applications to:
CareBreaks
Diocese of Providence
One Cathedral Square
Providence, RI 02903-3695

I certify, under penalty of perjury, that the information provide in this application is true and accurate.

Signature of Caregiver: _____ Date: _____

REV.4/22/13 CR

Application Instructions

To avoid any delay in processing application, please complete the entire application and include appropriate documentation. Application must be signed by the caregiver.

SECTION 1 – COMPLETE FOR *CARE RECIPIENT* INFORMATION:

Date of Birth: Acceptable proof includes a copy of the care recipient's birth certificate, driver's license, or State ID card.

Medical Diagnosis: Give a brief description of the medical diagnosis in the space provided on the application.

Income Information: **If care recipient is over the age of 18 years old** the amount of respite subsidy is based on the income of the care recipient and spouse, if applicable. If the care recipient is under the age of 18, the cost share is determined by their household income.*

SECTION 2 - COMPLETE FOR *CAREGIVER* INFORMATION:

Proof of the primary caregiver's address must be included with this application. Acceptable proof includes a copy of the caregiver's current driver's license, State ID card or a utility bill.

If the care recipient is under the age of 18, the cost share is determined by the household income. Married couples living together must report and verify income of both spouses.*

Income Verification Requirements: All income must be reported and verified. Married couples living together must report and verify income of both spouses. Acceptable proof includes a copy of your most recent Income Tax Return, 1099 Statements, Social Security award letter, pension checks, and bank statements. Also include proof of interest, dividends, rental income, stocks and bonds. If your tax return does not list your Social Security income (Form 1040A line 13a or Form 1040 line 20a), you must send us a benefit award letter or bank statement proving how much Social Security you received in addition to the income reported on your tax return. Also include any paid medical expenses.

Medical Expenses: Paid medical expenses that exceed 3% of your income may entitle you to a Medical Expense Deduction (MED). A MED can reduce your countable income and reduce your share of cost. Individuals applying on the basis of the last calendar year's income may report medical expenses paid during the previous 12 months prior to the month of application, or the previous 90 days if there have been significant changes to their income.

Medical expenses include paid bills from physicians, dentists, vision and hearing specialists and other health care professionals, medical insurance including Medicare premiums and deductibles, ambulatory health care facilities, prescription medicines, institutional care, dental, vision and hearing devices, prosthetic and auxiliary apparatus. Proof of ***claimed medical expenses*** must be included with your application. Acceptable proof includes copies of paid receipts from your health insurance plan, receipts or print-outs of paid pharmacy bills or any other paid medical bills.

* Be sure to include the appropriate information as outlined in Income Verification Requirements