Connecticut National Family Caregiver Support Program
Respite Care and Supplemental Services Application

GRANDPARENT/RELATIVE CAREGIVER APPLICATION

SENIOR RESOURCES—AGENCY ON AGING

Connecticut National Family Caregiver Support Program is funded by Title III E funds under an amendment to the Federal Older Americans Act. It is operated in partnership with the Connecticut State Department on Aging and the Connecticut Area Agencies on Aging.

The program offers an opportunity for grandparents or relative caregivers to receive respite and/or supplemental services from an approved community services provider for a child who is 18 years of age or younger, who is referred to as the care recipient. Respite care services include, but are not limited to camperships and day care. Funds may be used for daytime or overnight respite.*

The need for Respite and Supplemental Services:

Respite care is a SHORT-TERM option designed to provide a break, or a time of caregiver relief, from the constant physical and emotional stress of an older person caring for a child, especially children with skilled needs. An occasional break from caregiving enables the exhausted caregiver to regroup both physically and emotionally from his/her caregiver responsibilities.

Supplemental services are one time health-related items or service options designed to help "fill the gap" when there is a need or there are no other ways to obtain the service. Supplemental services will help improve the quality of life for the care recipient and help to alleviate the strain on older caregivers that care for children. Supplemental services include, but are not limited to receiving home safety/modifications and medical equipment.

A sliding fee scale is utilized to determine the recommended cost sharing for respite and supplemental services based on the grandparent/relative caregiver's monthly income. For those with income below federal poverty level, donations are accepted. Direct payment to a caregiver regardless of licensure is prohibited. Please talk with the Caregiver Program Coordinator for more details.

If you are:

A family caregiver for an older adult who is 60 years of age or older

Please complete Senior Resources "Services for Caregivers" Application

19 Ohio Avenue, Suite 2 • Norwich, CT 06360 • www.SeniorResourcesEC.org
Phone 860.887.3561 • 800.690.6998 • Fax 860.886.4736

Eligibility to receive Respite and/or Supplemental Services:

Definition: The term "Grandparent" or "Relative Caregiver" means a grandparent, step-grandparent, or a relative of a child by blood or marriage who is 55 years of age or older and

1) Lives with the child,
2) Is the primary caregiver of the child (18 years of age or younger) because the biological or adoptive parents are unable or unwilling to serve as primary caregiver of the child, and
3) Has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally.

Priority will be given to older individuals with greatest social and economic need, with particular attention to low-income older individuals and older individuals providing care and support to persons with intellectual disabilities and related developmental disabilities.

Income:
Income will be self-declared (proof of income will not be required). If the grandparent or relative caregiver has income at or below federal poverty level, he or she will be considered a priority for receiving services.

The following are considered income:
Social Security, Supplemental Security, Railroad Retirement income, pensions, wages, interest, dividends, net rental income, Veteran's benefits, and any other payments received on a one-time or recurring basis. If accounts are jointly owned between the grandparent/ relative caregiver and a spouse, 50% of the total interest income in the account will be counted as the grandparent's/relative caregiver's income.

PLEASE NOTE: Any income received for the child, for example child support, social security survivor's benefits, etc. will not be included as income.

***PLEASE NOTE NOT ALL SERVICES ARE AVAILABLE IN EACH REGION**

If you are:

A family caregiver for an older adult who is 60 years of age or older

Please complete Senior Resources "Services for Caregivers" Application

Senior Resources is a private non-profit organization which serves the needs of older persons as a focal point and resource center for information, program development, and advocacy.

Connecticut National Family Caregiver Support Program
Respite and or Supplemental Services
Grandparent/Relative Caregiver Application Form

Please complete the following application. Please do not leave and questions blank. PLEASE PRINT.

Caregiver's Name:_____ **Gender:** ◯Male ◯Female

Marital Status: ◯Never Married ◯Married ◯Widowed ◯Separated ◯Divorced

Date of Birth: _____/_____/_____ **Social Security Number:** **XXX/XX/**_____
MO/ DAY / YR (Last four digits only)

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

_____

Email Address:_____

Telephone: _____ _____ _____
Home **Work** **Cell**

Relationship to child/ren: ◯Grandparent ◯Other Relative_____
◯Other Non-Relative_____

Ethnicity: ◯Hispanic/Latino ◯Not Hispanic/Latino ◯Unknown

Race: ◯Non-Minority/White ◯Native American/Alaskan Native
◯Native Hawaiian/Pacific Islander ◯Asian ◯Black/African American
◯Hispanic/White ◯Other:_____

Disabled: ◯Yes ◯No If yes, please explain:_____

Type of Housing: ◯Private Home ◯Public Housing ◯Private Apartment
◯Other (please clarify)_____

Living Arrangements: ◯With Spouse & Grandchildren ◯With grandchildren only
◯Other_____

Please list each child that you are requesting respite/supplemental services for.

CHILD 1: _____ _____ Gender: ◯Male ◯Female
NAME (First and Last) AGE

Date of Birth: ___/___/____ Social Security Number: **XXX/XX/**_____

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:_____

Is child disabled? ◉Yes ◯No If yes, please explain_____

Please explain the type of assistance needed (If campership, after school program, or activity, please attach registration form.)

_____
_____
_____
_____

CHILD 2: _____ _____ Gender: ◯Male ◯Female
NAME (First and Last) AGE

Date of Birth: ___/___/____ Social Security Number: **XXX/XX/**_____

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:_____

Is child disabled? ◯Yes ◯No If yes, please explain_____

Please explain the type of assistance needed (If campership, after school program, or activity, please attach registration form.)

_____
_____
_____
_____

How did you hear about the Connecticut Family Caregiver Support Program?

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

_____

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

CAREGIVER MONTHLY INCOME STATEMENT

Please state the grandparent/relative caregiver's total monthly income. Income is considered as:

Social Security Supplemental Security Railroad Retirement Income
Pensions Wages Interest
Dividends Net Rental Income Veteran's Benefits
Any other payments received on a one-time or recurring basis

If accounts are jointly owned between the grandparent/relative caregiver and another person such as the spouse, 50% of the total interest income in the account will be counted as the grandparent's/relative caregiver's income.

PLEASE DO NOT INCLUDE ANY INCOME RECEIVED FOR THE CHILD/CHILDREN. ANY INCOME RECEIVED FOR THE CHILD, FOR EXAMPLE CHILD SUPPORT, SOCIAL SECURITY SURVIVORS BENEFITS, ETC. DO NOT COUNT AS INCOME.

Total monthly income:$_____ **Joint?** ☐Yes ☐No

Certification

I certify that the information on this form is true, accurate, and complete to the best of my knowledge or belief. I understand that if I provide false, fraudulent, or misleading information, I may face fines and/or penalties under state and/or federal laws.

_____ _____

Signature of Caregiver or Authorized Agent **Date**

Connecticut Family Caregiver Support Program

Respite and Supplemental Consumer Voluntary Contribution Agreement

I understand that I, _____ qualify to receive the services indicated in this application. I understand that as the caregiver and as the person requesting respite and/or supplemental services, I may be asked to make a contribution to help with the cost of the services received. The contribution shall be used to replenish program funds and therefore assist other caregiving families. The contribution shall be made directly to Eastern Connecticut Area Agency on Aging d/b/a Senior Resources.

I understand that if I have questions, I can call Senior Resources at:
1-800-690-6998 or 860-887-3561

_____ _____

Signature of Caregiver or Authorized Agent **Date**

Hold Harmless Statement

By authorized signature below, I hold **Senior Resources Agency on Aging**, Harmless from

- Any malpractice/other liability claims or legal actions resulting from action of sub-contractors acting as direct service providers
- Actions/omissions or other faults associated with warranties/maintenance agreements of sub-contractors/providers, instructional use of equipment and/or equipment failure, **OR**
- Care plan judgment made as a result of on-site assessments.

I understand that if I have questions, I can call Senior Resources at:
1-800-690-6998 or 860-887-3561

_____ _____

Signature of Caregiver or Authorized Agent **Date**

Please send completed application to:
Senior Resources Agency on Aging - 19 Ohio Avenue, Suite 2 - Norwich, CT 06360

Senior Resources
AGENCY ON AGING

PRIVACY NOTICE AKNOWLEDGEMENT

Client Name_____

I acknowledge that I have received Senior Resources - Agency on Aging's NOTICE OF PRIVACY PRACTICES.

_____ _____
Signed by Client Date of Signature

_____ _____
Signed on behalf of Client Date of Signature

If signed by Representative for Client:

_____ _____
Name Address

_____
Relationship to Client

_____
Date received by Senior Resources - Agency on Aging

Senior Resources
AGENCY ON AGING

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY

As your provider of care coordination services, we respect the privacy of your personal health information and are committed to maintaining your confidentiality. We are required by law to:

A. Maintain the privacy of your health information;
B. Provide you this detailed Notice of our legal duties and privacy practices relating to your health information; and
C. Abide by the terms of the Notice that are currently in effect.

I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR SERVICES AND HEALTH CARE OPTIONS

We have described these uses and disclosures below and provided examples of the types of uses and disclosures we may make in each of these categories.

For Services . We will use and disclose your health information in providing you with services and coordinating your care. We may disclose your health information to other providers involved in your care, such as physicians, nurses, physical therapists, occupational therapists, speech therapists, social workers, case managers, and home health aides.

For Health Care Operations . We may disclose your health information to another entity with which you have or had a relationship if that entity requests your information for certain of its health care operations or health care fraud and abuse detection or compliance activities. For example, health information of many patients may be combined and analyzed for purposes such as evaluating and improving quality of care and planning for services.

II. WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

Below are described ways in which we may use or disclose your health information.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify, including clergy, who is involved in your care.

Emergencies. We may use or disclose health information as necessary in emergency treatment situations.

Appointment Reminders. We may use or disclose health information to remind you about appointments.

Disaster Relief. We may disclose health information about you to a disaster relief organization.

As Required By Law. We may use or disclose your health information when required by law to do so.

To Avert a Serious Threat to Health or Safety. We may use or disclose health information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to prevent the threat.

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Public Health Activities. We may disclose your health information for public health activities. These activities may include, for example, reporting to a public health authority for preventing or controlling disease, injury or disability; reporting child abuse or neglect or reporting births and deaths, or to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure actions or for activities involving government oversight of the health care system.

Business Associates. We may disclose your protected health information to a contractor or business associate that needs the information to perform services for the Agency. Our business associates are also required to preserve the confidentiality of this information.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We may disclose information in response to a subpoena, discovery request, or other lawful process; efforts must be made to contact you about the request or to obtain an order or agreement protecting the information.

Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to comply with reporting requirements; to comply with a court order, warrant, or similar legal process; or to respond to certain requests for information concerning crimes.

Research. We may use or disclose your health information for research purposes if the privacy aspects of the research have been reviewed and approved, if the researcher is collecting information in preparing a research proposal, if the research occurs after your death, or if you authorize the use or disclosure.

Military, Veterans and other Specific Government Functions. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may disclose health information for national security purposes or as needed to protect the President of the United States or certain other officials or to conduct certain special investigations.

Workers' Compensation. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

Law Enforcement Custody. If you are under the custody of a law enforcement official or a correctional institution, we may disclose your health information to the institution or official for certain purposes including the health and safety of you and others.

Fundraising Activities. We may use certain limited information to contact you in an effort to raise funds for the Agency and its operations. You have the right to opt out of receiving such communications.

Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF PERSONAL HEALTH INFORMATION

We will use and disclose your personal health information (other than as described in this Notice or required by law) only with your written Authorization. You may revoke your Authorization in writing at any time. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes covered by that Authorization, except where we have already relied on the Authorization.

IV. YOUR HEALTH RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

Following is a listing of your rights regarding your personal health information. Exercise of these rights may require submitting a written request to the Agency. At your request, the Agency will supply you with the appropriate form to complete.

Right to Non-Disclosure of Certain Health Information Without Prior Written Authorization. Your prior written Authorization is required and will be obtained for most uses and disclosures of health information (1) that are psychotherapy notes; (2) for marketing purposes; (3) where we receive money in exchange for disclosing such health information; and (4) any other uses and disclosures of health information not described in this Notice of Privacy Practices.

Request Restrictions. You have the right to request restriction on our use or disclosure of your health information for treatment, payment, or health care operations. You also have the right to request restrictions on the health information we disclose about you to a family member, friend or other person who is involved in your care or the payment for your care.

We will honor your request for restriction on our use of disclosure of your health information when your request is with regard to treatment that is paid for out-of-pocket and in full and the disclosure would be solely for payment or health care operations purposes to a healthcare plan.

We are not required to agree to your other requested restrictions (except that if you are competent you may restrict disclosures to family members or friends). If we do agree to accept your requested restriction, we will comply with your request except as needed to provide you emergency treatment.

Right of Access to Personal Health Information. You have the right to inspect and obtain a copy of billing records or other written information that may be used to make decisions about your care, subject to some limited exceptions. Your request must be made in writing. We may charge a reasonable fee for our costs in copying and mailing your requested information.

We may deny your request to inspect or receive copies in certain circumstances. If you are denied access to health information, in some cases you have a right to request review of the denial. This review would be performed by a licensed health care professional designated by the Agency who did not participate in the decision to deny.

Right to Request Amendment. You have the right to request amendment of any information maintained by the Agency for as long as the information is kept by or for the Agency. Your request must be made in writing and must state the reason for the requested amendment.

We may deny your request for amendment if the information: **A.** Was not created by the Agency, unless the originator of the information is no longer available to act on your request; **B.** Is not part of the health information maintained by or for the Agency; **C.** Is not part of the information to which you have a right of access; or **D.** Is already accurate and complete, as determined by the Agency.

If we deny your request for amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial

Right to an Accounting of Disclosures. You have the right to request an "accounting" of our disclosures of your personal health information. This is a listing of certain disclosures made by the Agency or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, disclosure made pursuant to your Authorization, or certain other exceptions.

To request an accounting of disclosures, you must submit a request in writing, stating a time period that is within six years from the date of your request. The first accounting provided within a 12-month period will be free; further requests, we may charge you our costs.

Right to Notice of a Security Breach. You will be notified in the event of a security breach of your health information.

Right to Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner. We will accommodate your reasonable requests.

V. SPECIAL RULES REGARDING DISCLOSURE OF HIV, PSYCHIATRIC, AND SUBSTANCE ABUSE INFORMATION.

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment, special restrictions may apply. Except as provided below and as specifically permitted or required under state or federal law, health information relating to care for psychiatric conditions, substance abuse or HIV-related testing and treatment may not be disclosed without your special authorization.

HIV-related information:	For the purposes of treatment or payment, HIV-related information may be disclosed
Psychiatric information:	Psychiatric information may be disclosed if needed for your diagnosis or treatment in a mental health program. Limited information may be disclosed for payment purposes.
Substance abuse treatment:	With the exception of emergencies, if you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures.

VI. FOR FURTHER INFORMATION OR TO FILE A COMPLAINT

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Nancy Lisee, at Senior Resources - Agency on Aging at 860-887-3561. If you believe that your privacy rights have been violated, you may file a complaint in writing with the Agency or with the Office of Civil Rights in the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint. To file a complaint with the Agency, contact Nancy Lisee at 860-887-3561.

VII. CHANGES TO THIS NOTICE

We will promptly revise this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all health information already received and maintained by the Agency as well as for all health information we receive in the future. We will provide a copy of the revised Notice upon request.