



Services for Caregivers

Caregivers often find that the task of caring for another person can be overwhelming. They often develop stress-related illnesses such as heart disease, hypertension, or ulcers. An occasional break from caregiving enables an exhausted caregiver to regroup, both physically and emotionally, and find the strength to carry on.

Senior Resources Agency on Aging offers the following types of services for caregivers:

RESPIRE CARE: Respite care is a short-term option designed to provide a break from the physical and emotional stress of caregiving.

Respite care services include, but are not limited to: adult day care, home health aide, homemaker, companion, skilled nursing care, short term assisted living, or short term nursing home care. Funds may be used for daytime or overnight respite.

SUPPLEMENTAL SERVICES: 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 or item. Supplemental services help improve the quality of life for the care recipient and help to alleviate the strain on caregivers who care for older people.

Supplemental services include, but are not limited to, home safety modifications and medical related equipment.

Please Note: If you are a grandparent or relative caregiver for a child who is 18 years of age or younger, please complete Connecticut’s National Family Caregiver Support Program “Grandparent/Relative Caregiver Application”

ELIGIBLE CAREGIVERS

The term 'family caregiver' means an adult family member, or another individual who is an informal provider of in-home and community care.

Only family caregivers who provide care to an older individual with one or more of the following conditions are eligible to receive services under this program:

The care recipient:

1. Must be unable to perform at least two activities of daily living. Activities of daily living include bathing, dressing, toileting, eating, walking without substantial human assistance, including verbal reminding, physical cueing or supervision;
2. Has a cognitive or other mental impairment that requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to him or herself or to another individual;
3. Has Alzheimer's disease or a related dementia such as that which may result from: Multi infarct dementia, Parkinson's disease, Lewy Body Dementia, Huntington's disease, Normal Pressure Hydrocephalus, or Pick's disease. (The Applicant or authorized agent must provide a completed "Physician Statement" from a physician stating that the patient has been diagnosed with one of the above.)

GENERAL PRIORITY GUIDELINES

Priority will be given to:

- Older individuals with greatest social and economic need, with particular attention to low-income older individuals; OR
- Older individuals providing care and support to individuals with severe disabilities, including children with severe disabilities; OR
- Individuals with Alzheimer's disease or a related dementia.

PAYMENTS FOR SERVICES

Services are funded through the National Family Caregiver Support Program and the Connecticut Statewide Respite Care Program.

The National Family Caregiver Support Program is funded by the Administration on Aging and is operated in partnership with the State of Connecticut Department of Social Services and the Connecticut Area Agencies on Aging.

The Connecticut Respite Care Program is funded by the State of Connecticut Department of Social Services, and is operated in partnership with the Alzheimer's Association, Connecticut Chapter, and the Connecticut Area Agencies on Aging.

Senior Resources may request a contribution or co-payment of 20% towards the cost of the service.

Direct payment to a caregiver is prohibited.

Please talk with Senior Resources' staff for more details.

INCOME

All income and assets are based on the care recipient NOT the caregiver.

The following are considered income: Social Security (minus Medicare Part B premiums), 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 a care recipient and another person such as the spouse, 50% of the total interest income in the account will be counted as care recipient's income.

ASSETS

The following are considered liquid assets: Checking accounts, savings accounts, and individual retirement accounts, certificates of deposits, stocks, or bonds that can be converted into cash within 20 working days. If assets are jointly owned with a spouse, 50% of the total asset value will be counted as the care recipient's asset.

If there is an individual authorized to act on behalf of the care recipient (such as a Conservator or Power Of Attorney), please provide documentation of this designation.

PHYSICIAN STATEMENT

The physician statement must be completed by a physician familiar with the care recipient's condition, even if there is no known diagnosis of dementia.

Please send completed application including all documentation to:

**Senior Resources – Agency on Aging
4 Broadway, 3rd Floor
Norwich CT 06360
860-886-4736 (fax)**

**Questions or additional information, please call:
860-887-3561 or 1-800-690-6998**

APPLICATION FORM

Revised 06/08

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

FAMILY CAREGIVER INFORMATION

Caregiver's Name: _____ Gender: Male Female

Marital Status: Never married Married Widowed Separated Divorced

Date of Birth: ____/____/____
MO/DAY/YR

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: _____

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.**

CARE RECIPIENT INFORMATION:

Care Recipient's Name: _____

Marital Status: (Please check the one that applies to the care recipient) Never married Married Widowed Separated Divorced**Gender:** Male Female**Veteran or dependent:** Yes No**Age:** _____ **Date of Birth:** ____/____/____
MO/DAY/YR**Social Security Number:** _____ - _____ - _____**Address, if different from the Caregiver:**_____
Street_____
City/CT/Zip

Telephone: _____ (if different than Caregiver)

Type of Housing: (Please check the one that applies to the care recipient)

- Private home Board and care home Senior Housing Public housing
 Private apartment Nursing home/Institution Congregate housing
 Other: _____

Living Arrangement (Please check the one that applies to the care recipient)

- Alone With spouse only With spouse & children With children only
 Other: _____

Primary Physician: _____ **Telephone:** _____**Medical Diagnosis:** _____

_____**Any Pets:** _____**Smoker:** Yes No

1. Does the care recipient currently receive **MEDICAID (TITLE 19)**? Yes No
If No, is the care recipient currently applying for **MEDICAID (TITLE 19)**? Yes No

2. Does the care recipient currently receive services from the other respite programs?
 Yes No
If no, is the care recipient currently applying for services from another respite program?
 Yes No

3. Does the care recipient currently receive services from the **CT Home Care Program for Elders**?
 Yes No
If no, is the care recipient currently applying for the **CT Home Care Program for Elders**?
 Yes No

4. Explain the reason that the caregiver is requesting services: _____

5. Explain the type of assistance that is needed: _____

6. Does the care recipient receive any additional home or community based services? If yes, please list the services: _____

7. Note the name of any agency you are currently using or would like to use: _____

INCOME STATEMENT

Please list care recipient's sources of income. The following **are** considered income: Social Security (**minus** the Medicare Part B and Part D Premiums), Supplemental Social Security, Railroad Retirement Income, pensions, wages, interest, dividends, net rental income, veteran's benefits, and **any** other payment received on a one-time or recurring basis.

If the income is from a joint (**spouse only**) asset, indicate so by writing "**yes**" in the appropriate column.

	Monthly Amount	Joint?
1. Social Security (minus Medicare premiums), SSI, and Railroad Retirements	\$ _____	_____
2. Pensions, retirement income, annuities	\$ _____	_____
3. Veteran' Benefits	\$ _____	_____
4. Interest and Dividends	\$ _____	_____
5. Other income (wages, net rental income, non-taxable income)	\$ _____	_____
TOTAL AMOUNT OF INCOME	\$ _____	

Does the spouse have income separate from the applicant?

NO YES

If yes, approximate amount? \$ _____

LIQUID ASSET INFORMATION

Please indicate liquid assets of the care recipient and his or her spouse. Liquid assets are defined by this program to be those assets 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, and bonds.** **Include all accounts in the applicant's name as well as those in both the applicant and their spouse's name.** If the account is jointly owned, indicate so by writing "yes", and with whom, in the appropriate column.

Liquid Asset	Amount	Joint?	Whom?
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
_____	\$ _____	_____	_____
TOTAL AMOUNT OF LIQUID ASSETS	\$ _____		

Does the spouse have assets separate from applicant?

NO YES

If yes, approximate amount \$ _____

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 association 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.

Signature of Caregiver

Date

I also understand that if I have questions I can call:

**Senior Resources Agency on Aging • 4 Broadway, 3rd Floor • Norwich, CT 06360
860-887-3561 or 800-690-6998 (in State only)**

PHYSICIAN STATEMENT

An application has been made to Senior Resources - Agency on Aging 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: _____

Does this patient have irreversible and deteriorating dementia of the Alzheimer's type?

- Yes No

Is there a secondary source of dementia?

- | | |
|--|---|
| <input type="checkbox"/> Multi Infarct Dementia | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Lewy Body Dementia | <input type="checkbox"/> Huntington's Disease |
| <input type="checkbox"/> Normal Pressure Hydrocephalus | <input type="checkbox"/> Pick's Disease |

Other: _____

SIGNATURE OF PHYSICIAN

DATE

Name of Physician (Please Print or Type): _____

Address: _____

Telephone: _____

Please return form to:

**Senior Resources Agency on Aging • 4 Broadway, 3rd Floor • Norwich, CT 06360
860-887-3561 or 800-690-6998 (in State only)**

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information on:

Name of Patient

Address

Phone

Date of Birth

SIGNATURE OF CAREGIVER OR AUTHORIZED AGENT

DATE

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

Please return this form to:

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**THIS NOTICE DESCRIBES HOW
INFORMATION ABOUT YOU
MAYBE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS
TO THIS INFORMATION. PLEASE
REVIEW IT CAREFULLY.**

Introduction

Senior Resources - Agency on Aging,

We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. The Notice is effective 4/14/03 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Senior Resources - Agency on Aging, or a member of our staff visits you, a record of your visit is made. Typically, this record may contain your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- * Basis for planning your care and treatment
- * Means of communication among the many health professionals who contribute to your care,
- * Legal document describing the care you received,
- * Means by which you or a third-party payer can verify that services billed were actually provided,
- * A tool in educating health professionals
- * A source of data for medical research,
- * A source of information for public health officials charged with improving the health of this state and the nation,
- * A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

A. Your Health Information Rights

You have the following rights regarding your protected health information that we maintain:

1. The Right to Access Your Personal Protected Health Information:

Upon written request, you have the right to inspect and obtain a copy of your protected health information contained in clinical, billing and other records used to make decisions about you. Under state law, if we make a copy of your protected health information, we will not charge you more than is permitted by the current rate allowed by state law for copies. You should submit your written request to access your health information of our contact person who is listed on this notice.

We may deny your request to inspect or receive copies in certain limited situations. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

2. The Right to Request Restrictions:

You have the right to request a restriction on the way we use or disclose your protected health information for treatment, payment, or health care operations. However, even if we agree to your request, in certain situations your

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restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection D.

3. The Right to Request Confidential Communications:

You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. You should submit your written request for Confidential Communication to our contact person who is listed in the Notice. You must tell us how and where you want to be contacted. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

4. The Right to Request and Amendment:

You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you. Your request must be made in writing and must explain your reasons(s) for the amendment. We may deny your request if the information:

- a. Was not created by us (unless you prove the creator of the information is no longer available to amend the record);
- b. is not part of the records maintained by us;
- c. in our opinion, is accurate and complete;
- d. is information to which you do not have a right of access.

If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial and explain to you that you have the right to submit a written statement disagreeing with the denial. Your letter of disagreement will be attached to your medical record. You should submit your written request for an amendment to our contact person who is listed in this Notice.

5. The Right to an Accounting of Disclosures:

If you ask our contact person in writing, you have the right to receive a written list of certain disclosures we made about you when using your protected health information. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). We are not required to include disclosures:

- a. For you treatment
- b. For billing and collection of payment for your treatment
- c. For our health care operations
- d. Requested by you, that you authorized, or which are made to individuals involved in your care.
- e. Allowed by law when the use and/or disclosure related to certain specialized government functions or relates to correctional institutions and in other law enforcement custodial situations, and,
- f. As part of a limited set of information which does not contain certain information which would identify you.

The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee. You must submit your request of a listing of disclosures in writing to the contact person who is listed in this notice along with the time period for which you would like the list.

6. The Right to a Paper Copy of This Notice:

You have the right to request a paper copy of this Notice at any time by contacting our office in writing or by phone. We will provide a copy of the Notice no later than the date you first receive service from us (except for emergency services),

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and then we will provide the Notice to you as soon as possible.

B. Our Responsibilities

Senior Resources is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we are unable to agree to a requested restriction, and
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provision effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we received a written revocation of the authorization according to the procedures included in the authorization.

C. For More Information or to Report a Problem

If you have questions and would like additional information you may contact our Privacy Officer: Nancy Krodel, Senior Resources, 4 Broadway, 3rd Floor, Norwich, CT. (860) 887-3561 or 1-800-690-6998.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Dept. of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington D. C. 20201

D. Examples of Disclosures for Treatment, Payment and Health Operations

1. We will use your health information for treatment.

For example: Information obtained by the case manager may be used to determine the treatment (care plan) that works best for you. Your case worker may document his or her expectations and observations in order to determine how you are responding to treatment. We will also provide your physician or subsequent health care provider with copies of various reports that should assist him or her in your treatment. This is to include all health care providers in our practice and those assisting in coverage of our practice.

2. We will use your health information for payments.

For example: A bill may be sent to you or a third-party payer.

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The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

3. We will use your health information for regular health operations.

For example: Members of the assessment review committee may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples of our business associates include but are not limited to Home Health Care Agencies, Visiting Nurse Associations, Adult Day Care Agencies, Assisted Living, and Nursing Home facilities. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

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

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

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may leave a message on your answering machine or on voice mail as a means of communication. We may mail you a postcard or written notice as a means of communication. We may email you or our transcriptionist as a means of communication.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

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.

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.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related 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.

* Psychiatric information: If needed for your diagnosis or treatment in a mental health program, psychiatric information may be disclosed. Certain limited information may be disclosed for payment purposes.

* HIV-related information: HIV-related information may be disclosed for purposes of treatment or payment.

* Substance Abuse Treatment: If you are treated in a specialized substance abuse program, your special authorization will be needed for most disclosures, not including emergencies.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

We are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your health information as defined by federal regulations.

Please sign below to indicate that you have received a copy of our Privacy Notice. If you have any questions regarding this Notice, please contact our Privacy Officer, Nancy Krodel at 1-800-690-6998.

Date: _____

NOTICE OF PRIVACY POLICIES FOR: (Name) _____

(Address) _____

(860) _____
(Telephone Number)

(Signature)

The enclosed copy of the Privacy Notice should be kept with your records.