APPLICATION FOR CAREGIVER ASSISTANCE

GUIDELINES

- The patient must be diagnosed by a practicing, certified physician as suffering from “Alzheimer’s disease”, “probable Alzheimer’s disease”, or “dementia of Alzheimer’s type.” The physician’s statement must have one of the above diagnoses for the patient to be eligible.

- Grants are provided for expenses such as short-term nursing care, home health care, respite care, adult day care, medications, medical or personal hygiene supplies, transportation, and other expenses related to care for a patient with Alzheimer’s disease. Grants are not provided for payment of nursing home fees.

- Eligible applicants may receive grants of up to $500 on the basis of need for such expenses as home health care, respite care, adult day care, medications, medical supplies, personal hygiene supplies and other expenses related to patient care.

- Applications are funded based on established need and on a first-come, first-served basis. First-time applicants will receive priority treatment; repeat applicants are placed on a waiting list and are considered as funding becomes available. The Carol Ann Sanders Foundation depends on charitable contributions from the sale of artwork in order to fund grants. Therefore, the amount of assistance that can be provided, as well as the total number of patients who can be helped, is determined by the availability of funds. At times, it may be necessary to place an approved request on a waiting list until funds become available.

- Liquid assets (which includes cash, checking and savings accounts, money market accounts, stocks, bonds, and mutual funds) of the patient and caregiver may not exceed $10,000. Liquid assets do not include the patient’s car or house. However, all of the patient’s assets will be taken into consideration in determining urgency of need.

- Applications must include original signature and a corroborating statement from the patient’s physician, health professional or social worker before they are presented to the CASF Review Committee for consideration for funding.

- The extent to which assistance can be provided, as well as the number of patients who can be helped, is determined by the availability of funds. At times, it may be necessary to place an approved request on a waiting list until funds become available.

- Grant recipients or candidates who have been denied funding may apply more than once, but they must wait to reapply until the following calendar year. Applicants are encouraged, however to explore alternative sources for additional help.

If you have any questions concerning Alzheimer’s disease or specific treatment options, we recommend you consult a qualified physician, or visit the Alzheimer’s Association online at www.alz.org for more information.

INSTRUCTIONS

- Please complete the entire application. All information on the application will be taken into consideration in determining the urgency of need. Failure to complete all sections of the application will result in a delay in reviewing the application.

- The physician’s diagnosis should be included with the application and should be written on the physician’s stationery or prescription pad. Original documentation with the physician’s actual signature must be submitted; no photocopies or stamped signatures by the physician will be accepted.

- All applications, whether denied or approved, will receive notification in writing. If denied, the letter will include an explanation of denial. A copy of the letter will also be sent to the social worker/health professional listed in the application.

- Submit completed application and required paperwork to the Carol Ann Sanders Foundation, Attn: Review Committee, 4903 Park Drive, Monticello, MN 55362. The Review Committee meets the 20th of each month.

APPLICATION FOR CAREGIVER ASSISTANCE

Please type or print all information in blue or black ink.

INFORMATION ABOUT THE PATIENT

Patient's Name: ______________________________ Marital Status: S M D W

Date of Birth: ______________ Social Security Number: ______________________

Address: ____

City: ______________________ County: ______________________

State: ____________ Zip: ____________ Telephone: (_____) ________________

INFORMATION ABOUT THE CAREGIVER

Caregiver's Name: ______________________________ Marital Status: S M D W

Date of Birth: ______________ Social Security Number: ______________________

Address: ____

City: ______________________ County: ______________________

State: ____________ Zip: ____________ Telephone: (_____) ________________

Relationship to patient: ____

Is the patient your dependent? Yes No

Do you have any other dependents? Yes No (If yes, give number of dependents): ________________

Have you applied for CASF assistance for yourself or the patient before? Y / N (If yes, give date): ____________

Under penalty of perjury, I declare that to the best of my knowledge this statement of assets, liabilities and other information is truthful, complete and accurate. I guarantee that all monies received from the Carol Ann Sanders Foundation will be used for expenses incurred as a result of the patient's Alzheimer's disease.

Signature of Patient: ______________________________ Date: ____________

If patient is unable to sign, signature of individual authorized to sign on patient's behalf:

Signature: ______________________________ Date: ____________

Name (please print): ____

Type of signature authority (durable power of attorney, guardian, etc.): ________________

Please attach copies of all legal paperwork/documentation.

PATIENT/CAREGIVER STATEMENT OF NEED

To be filled out by Patient or Caregiver. Please describe in detail the need for which you are requesting a grant and why this is an urgent need:

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Signature: ______________________________

GRANT REQUEST

Specify the type and amount of financial assistance you are applying for (not to exceed $500):

TYPE OF ASSISTANCE	AMOUNT
Short-term nursing care	$ __________
Home health care	__________
Respite care	__________
Adult day care	__________
Medications	__________
Medical supplies	__________
Transportation Expenses	__________
Personal hygiene supplies	__________
Nutritional supplements	__________
Other patient care expenses	__________
TOTAL AMOUNT REQUESTED:	**$** __________

Grant check to be made to: ______________________________

Mail check to: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: ____________

Telephone: (_____) ______________________________

Checks cannot be made payable to individuals who do not have legal authority to act on patient's behalf.

Please attach copies of all legal paperwork/documentation.

PATIENT/CAREGIVER FINANCIAL INFORMATION

This information will be kept strictly confidential. Please provide information for both Patient and Caregiver.

ASSETS

	Patient	Caregiver & Spouse
LIQUID ASSETS		
Checking Account	$ ________	$ ________
Savings/Money Market	________	________
Stocks & Bonds	________	________
Other Liquid Assets	________	________
FIXED ASSETS		
Home (assessed value)	________	________
Auto	________	________
Other Assets	________	________
TOTAL ASSETS	**$ ________**	**$ ________**

LIABILITIES

	Patient	Caregiver & Spouse
Mortgage (Remaining)	$ ________	$ ________
Auto Loan	________	________
Other Liabilities	________	________
TOTAL LIABILITIES	**$ ________**	**$ ________**

MONTHLY INCOME

	Patient	Caregiver & Spouse
Net Pay (if employed)	$ ________	$ ________
Retirement Income	________	________
Social Security	________	________
Veteran's Benefits	________	________
Other Income	________	________
TOTAL MONTHLY INCOME	**$ ________**	**$ ________**

MONTHLY EXPENSES

	Patient	Caregiver & Spouse
GENERAL		
Rent/Mortgage	$ ________	$ ________
Food	________	________
Utilities	________	________
Transportation	________	________
Auto Payment	________	________
INSURANCE		
Medical/Dental	$ ________	$ ________
Life	________	________
Homeowner/Renter	________	________
Auto	________	________
MEDICAL		
Nursing Care	$ ________	$ ________
Respite Care	________	________
Day Care	________	________
Doctor Fees	________	________
Hospital Fees	________	________
Medications	________	________
Personal Hygiene Items	________	________
Other Expenses	________	________
TOTAL MONTHLY EXPENSES	**$ ________**	**$ ________**

SOCIAL WORKER/HEALTH PROFESSIONAL REVIEW

This section must be filled out by a social worker or health professional other than the diagnosing physician. This can include a home health nurse or day care center nurse.

Name and Title: ____

Agency or Facility: ____

Address: ____

City: ____ State: ________________ Zip: ______________

Telephone: (_____) ________________ Fax: (_____) ________________ Email: ____________________

Patient's Name: ____

Caregiver's Name: ____

Please review this application for financial assistance from the Carol Ann Sanders Foundation for completeness and compliance with instructions. Please provide us with any further information, comments, and recommendations that will enable us to fully evaluate this application. If you have any questions, please call (651) 492-0930.

Is the patient eligible for and receiving:

1. Medicare benefits? Y N
2. Medicaid benefits? Y N
3. Health insurance/Medigap insurance? Y N
   (If yes, please describe below.)
4. Other assistance programs? Y N
   (If yes, please describe below.)

Is the caregiver eligible for and receiving:

1. Medicare benefits? Y N
2. Medicaid benefits? Y N
3. Health insurance/Medigap insurance? Y N
   (If yes, please describe below.)
4. Other assistance programs? Y N
   (If yes, please describe below.)

Have all other public and private funding sources been identified and applied for? Y N
If no, please explain below.

COMMENTS: (Must be filled out)

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I attest that the information provided on this form is complete and accurate to the best of my knowledge.

Social Worker/
Health Professional Signature: ____ Date: ______________

RELEASE OF INFORMATION

In an effort to inform the public about the crisis faced by Alzheimer's patients and their caregivers, CASF uses testimonials from the patients and caregivers who have received help. These testimonials generate the support that enables CASF to provide assistance to individuals like you. It would be helpful to us if you would sign the Release of Information below. Be assured that this is not a prerequisite to obtain assistance from CASF. If your case history is used, only the facts about your situation will be included. We will not use your full name or exact location.

"I consent to the use of my case history to help others know that financial assistance is available through the Alzheimer's Financial Assistance Program, a program made possible by the Carol Ann Sanders Foundation."

Patient's Name: ______________________________

Caregiver's Name: ______________________________

Caregiver's Signature: ______________________________ Date: ______________

FOR CASF USE ONLY

Date Application Received: ______________________________

Date Application Completed: ______________________________

Application was (circle one) Approved Denied

TYPE OF ASSISTANCE	AMOUNT
Short-term nursing care	$ ________
Home health care	________
Respite care	________
Adult day care	________
Medications	________
Medical supplies	________
Transportation Expenses	________
Personal hygiene supplies	________
Nutritional supplements	________
Other patient care expenses	________
TOTAL AMOUNT REQUESTED:	**$** ________

Reviewer #1 Signature: ______________________________ Date: ______________

Reviewer #2 Signature: ______________________________ Date: ______________

Check Number: ______________ Date: ______________ Amount: $ ______________

Comments and Notes: