ALZHEIMER'S OF CENTRAL ALABAMA
Scholarship Application for Adult Day Care

BEFORE COMPLETING APPLICATION PLEASE READ CAREFULLY:

- **ACA Scholarships are awarded without regard to race, color, religion, sex or age.**
- **ACA selects scholarship recipients based on need.**
- **All scholarship recipients must have a caregiver.**
- **All applications will be kept on file for one year.**

ANSWER ALL QUESTIONS IN THIS APPLICATION FORM. INCOMPLETE APPLICATIONS CANNOT BE CONSIDERED.

Please print clearly or type

GENERAL INFORMATION ABOUT THE PATIENT: DATE_____

Patient's Name _____

Address _____

_____ **County**_____

Telephone Number _____ **Date of Birth** _____

Diagnosis _____

Length of Illness _____

GENERAL INFORMATION ABOUT THE CAREGIVER:

Caregiver's Name _____

Address _____

_____

Home # _____ **Work Number #** _____

Cell # _____ **Email** _____

Caregiver Date of Birth _____ **Relationship to Patient** _____

CAREGIVER VIGILANCE

The following questions concern the time you spend supervising, or just "being around" for your patient.

Does the patient live with the primary caregiver?
o No o Yes

How long has the primary caregiver been providing care for the patient?
o 1-3 Years o 3-5 Years o 5-10 Years o More than 10 years

How many people reside in the home? _____

What are their relationships to the patient? Check all that apply**:**
o Spouse o Sibling o Son o Daughter o Daughter or Son in Law

o Grandchildren o Other (specify) _____

How often do you (or the primary caregiver) get a break?
o Never o Once a month o Once a week o Daily

Are you able to leave your patient home alone, that is with no one else there?
❑ No ❑ Yes

Can your patient be left alone in a room as long as someone is in the house?
o No o Yes

About how many hours a day do you feel the need to "be there" or "on duty" to care for your patient?

_____ Hours

About how many hours a day do you estimate that you are actually doing things for your patient?

_____ Hours

FORMAL SERVICES

The following questions concern services the patient may be receiving.

Is the patient currently attending an adult day care center?
o No o Yes If yes which one _____

Is the patient on hospice care?
o No o Yes

Has the patient ever been on hospice care?
o No o Yes

Is the patient a veteran or a spouse of a veteran?
o No o Yes

Does the patient receive any VA benefits?
o No o Yes
If so what benefits? _____

Does the patient receive SSI?
o No o Yes

Does the patient receive Medicaid Waiver?
o No o Yes
If so list the name and phone number of their caseworker**:** _____

_____

The following questions concern the services that you or your patient may have received in the past month from an agency or from someone paid privately to provide this help.

	No	**Yes**	**In the past month how often did you make use of this of this service?**
Do you or your patient have a homemaker who helps with shopping, cleaning, preparing meals, laundry, etc.?	❑	❑	_____ times/month
Do you or your patient have a home health aide come to the home to help with personal care, i.e., bathing, feeding, and health care tasks?	❑	❑	_____ times/month
Do you or your patient have a visiting nurse come to check medications, blood pressure or other medical needs?	❑	❑	_____ times/month
Do you or your patient have a hospice service visiting?	❑	❑	times/month _____

PATIENT HEALTH - Does your patient have any of the following health problems?

High Blood Pressure	❑ No	❑ Yes
Heart Condition	❑ No	❑ Yes
Chronic Lung Disease	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
Cancer	❑ No	❑ Yes
Stroke	❑ No	❑ Yes
Urinary Tract Infections	❑ No	❑ Yes
Falls	❑ No	❑ Yes

Does the patient have a diagnosis of Alzheimer's disease or dementia?
o No o Yes

Please give the name and phone number of the patient's primary physician**:** _____

_____

Does the patient suffer from memory problems?
o No o Yes

Does the patient have trouble with any of the following?
o Bathing o Dressing o Toileting o Walking o Eating

Does the patient take any medication for sleep or mood?
o No o Yes

BEHAVIORAL ISSUES

Does the patient wander or get lost?
o No o Yes

Does the patient resist attempts to care for them?
o No o Yes

Is the patient verbally abusive?
o No o Yes

Does the patient sleep through the night?
o No o Yes

Is the patient willing to take their medications?
o No o Yes

Is the patient cooperative when being bathed and dressed?
o No o Yes

ELIMINATION

Elimination Patterns:

	Yes	Sometimes	Never
Able to control bowel function	❑	❑	❑
Able to control bladder function	❑	❑	❑

CAREGIVER HEALTH

Please rate your overall physical health**:**
o Good o Fair o Poor

Please rate your mood or mental health**:**
o Good o Fair o Poor

Do any of the following problems interfere with you giving care to your patient?

- ❑ Heart
- ❑ Arthritis/joint problem
- ❑ Loss of sleep
- ❑ Other (specify) _____
  _____
  _____

Please describe any health problems that interfere with your ability to care for the patient:

_____
_____
_____
_____

Why are you seeking an adult day care center for your patient? Check all that apply:

- o Caregiver is still employed
- o Caregiver's health
- o Caregiver needs a break
- o Patient is bored at home
- o Patient has behavioral issues

Over the past month, how satisfied are you with the amount of time you have been able to spend:

	Not at all	**A little**	**A lot**
Quiet time by yourself?	❑	❑	❑
Attending church or going to other meetings of groups or organizations?	❑	❑	❑
Taking part in hobbies or other interests?	❑	❑	❑
Going out for meals or other social activities?	❑	❑	❑

	Not at all	**A little**	**A lot**
Doing fun things with other people?	❑	❑	❑

Visiting with family and friends? ❑ ❑ ❑

HOUSEHOLD INCOME

Please check the sources of income for ALL adults living in the home:

o Employment o Social Security o Support from children or other family

o Aid for Dependent Children (AFDC) o VA o Work related pensions

o Bank interest, retirement accounts, rental property, investments, etc.

What category best describes the yearly total household income before taxes of ALL adults in the house?

❑ Less than $5,000
❑ $5,000 - $9,999
❑ $10,000 - $14,999
❑ $15,000 - $19,999
o $20,000- $29,000
❑ $30,000 - $39,999
❑ $40,000 - $49,999
❑ $50,000 and above

How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:

❑ Not difficult at all ❑ Somewhat difficult

❑ Not very difficult ❑ Very difficult

Please list any health related costs related to your patient that you must pay for each month. (For example, prescriptions, incontinence products, adult diapers, etc.)

Item	Approximate Cost
1.	
2.	
3.	
4.	
5.	

This page is to be completed by the primary caregiver or referral source.

Please use this section to give insight into the patient's circumstances. Give particular emphasis to financial need and need for formal support services.

Signature: _____ **Date:** _____

Print Name: _____

Position/Title: _____

Telephone Number(s): _____

SIGNATURE PAGE

Please sign and return with application

I verify that all information contained in the application is correct and valid. I understand that at any time my scholarship could be revoked if any information found in the application is deemed to be invalid.

_____ _____

Caregiver Signature **Date**

I hereby give authorization for the release of information to the ACA Scholarship Committee.

_____

(Patient Name)

_____ _____

Caregiver Signature **Date**

Before returning application, check to be certain that:

1) **All questions have been answered**

2) **The signature page has been signed**

3) **Reference sheet (page 7) is complete**

Please send forms containing above items to:

ALZHEIMER'S OF CENTRAL ALABAMA
ATTN: PATIENT & FAMILY SERVICES
PO BOX 2273
BIRMINGHAM AL 35201-2273