



Family Support Scholarship Application

Use this application to request one or more ACA family support scholarships. Complete the shared sections and only the program sections for the assistance requested.

APPLICATION INFORMATION

Scholarships are awarded based on need and without regard to race, color, religion, sex, or age. Each recipient must have a caregiver. Applications are kept on file for one year. Submission does not guarantee assistance. Please answer every question that applies to your request.

Person completing this application: ☐ Primary caregiver ☐ Referral source ☐ Family or friend

Name: _____

Phone: _____ Email: _____

How did you hear about ACA? ☐ Online search ☐ Community organization: _____

☐ Healthcare provider ☐ Friend/family ☐ Other: _____

Assistance requested:
(check all that apply) ☐ Adult Day Care ☐ Continence Products ☐ Nutritional Drinks

PERSON LIVING WITH DEMENTIA

Full legal name: _____

Street address: _____

City, state, ZIP: _____

County: _____ Telephone number: _____

Diagnosed with Alzheimer's disease or another dementia? ☐ No ☐ Yes

If No, are you seeing a doctor for memory problems to get a diagnosis? ☐ No ☐ Yes

If No, ACA's scholarships are for people with an Alzheimer's or other dementia diagnosis.

Please call the office with questions: 205-871-7970.

Approximate date or year of diagnosis: _____

Primary physician, practice, and telephone: _____

Person's date of birth: _____

Person's gender: ☐ Female ☐ Male ☐ Self-describe: _____ ☐ Prefer not to answer

Person's race and ethnicity (check all that apply):

- | | | |
|--|--|---|
| ☐ American Indian/Alaska Native | ☐ Hispanic/ Latino | ☐ White |
| ☐ Asian | ☐ Middle Eastern/North African | ☐ Prefer not to answer |
| ☐ Black/African American | ☐ Native Hawaiian/ Pacific Islander | |

Did the person ever serve active duty in the U.S. Armed Forces?

- ☐ Yes ☐ No ☐ Prefer not to answer

What language is mainly spoken at home? ☐ English ☐ Spanish ☐ Other: _____

PRIMARY CAREGIVER

Caregiver's full name: _____

Caregiver age: _____

Relationship to person living with dementia: ☐ Spouse/partner ☐ Sibling ☐ Son
☐ Daughter ☐ Son- or daughter-in-law ☐ Grandchild ☐ Other: _____

Street address (if different): _____

City, state, ZIP: _____

Preferred telephone: _____

Alternate telephone: _____

Email: _____

Preferred method of communication: ☐ Phone ☐ Text ☐ Email

May ACA leave a voicemail on your preferred telephone: ☐ No ☐ Yes

May ACA send text messages to your preferred number: ☐ No ☐ Yes

CAREGIVING SITUATION

Does the person live with the primary caregiver? ☐ No ☐ Yes

How long has the primary caregiver been providing care?

- ☐ Less than 1 year ☐ 1-3 years ☐ 3-5 years ☐ 5-10 years ☐ More than 10 years

How many additional people live in the home? _____

Relationship of each additional household member to the caregiver (check all that apply):

- | | | | |
|--|-------------------------------------|---------------------------------------|-----------------------------------|
| ☐ Spouse/partner | ☐ Sibling | ☐ Son | ☐ Daughter |
| ☐ Son- or daughter-in-law | ☐ Grandchild | ☐ Other: _____ | |

How often does the caregiver get a meaningful break?

- ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily

Can the person safely remain home alone? ☐ No ☐ Yes

Can the person remain alone in a room while someone else is home? ☐ No ☐ Yes

Approximate hours per day the caregiver feels 'on duty': _____

Approximate hours per day providing hands-on assistance: _____

CURRENT SERVICES AND BENEFITS

What services and benefits are currently used by the person with dementia? (check all that apply)

- | | |
|--|--|
| ☐ Hospice care | ☐ Homemaker or household assistance |
| ☐ Veteran or spouse of a veteran | ☐ Home health aide or personal care |
| ☐ Receives VA benefits | ☐ Visiting nurse |
| ☐ VA Disability | ☐ Hospice visits |
| ☐ VA Aid & Attendance | ☐ Meals on Wheels |
| ☐ VA Caregiver Services | ☐ Alabama CARES |
| ☐ Receives SSI | ☐ Another Unity Way program |
| ☐ Receives Medicaid Waiver services | ☐ Respite or adult day care |
| ☐ Public Assistance – food, cash, utilities | Location: _____ |

Have you applied to any other organization for the same assistance? ☐ No ☐ Yes

If yes, please share the organization name and the status of your application. _____

HEALTH AND DAILY SUPPORT NEEDS

What dementia diagnosis has the person received?

- | | | |
|---|---|--|
| ☐ Alzheimer's Disease | ☐ Vascular Dementia | ☐ Dementia with Lewy Bodies |
| ☐ Frontotemporal Dementia | ☐ Mixed Dementia | |
| ☐ Parkinson's Disease Dementia | ☐ Atypical Alzheimer's | |

What additional health conditions does the person with dementia have? (check all that apply)

- | | |
|---|---|
| ☐ High blood pressure | ☐ Cancer |
| ☐ Heart condition | ☐ Stroke |
| ☐ Chronic lung disease | ☐ Recurring urinary tract infections |
| ☐ Diabetes | ☐ History of falls |
| ☐ Other significant health conditions: _____ | |

Needs help with (check all that apply):

- | | | | | |
|--|-----------------------------------|------------------------------------|---|---------------------------------|
| ☐ Bathing | ☐ Dressing | ☐ Toileting | ☐ Walking/transferring | ☐ Eating |
| ☐ Medication management ☐ Other: _____ | | | | |

Takes medication for sleep or mood? ☐ No ☐ Yes

SAFETY AND BEHAVIOR

Does the person with dementia do the following?

	No	Yes
Wanders or becomes lost	☐	☐
Resists attempts to provide care	☐	☐
Uses verbally aggressive language	☐	☐
Sleeps through the night	☐	☐
Willingly takes medications	☐	☐
Cooperates with bathing and dressing	☐	☐

MOBILITY AND CONTINENCE

Is the person confined to bed? ☐ No ☐ Yes

If no, can they

Get out of the house

Walk around inside the house

Transfer between bed, chair, wheelchair, or commode

Without help

With help

Unable

☐
☐
☐
☐
☐
☐
☐
☐
☐

Usually

Sometimes

Rarely/ Never

Controls bowel function

☐
☐
☐
☐
☐
☐

Controls bladder function

☐
☐
☐
☐
☐
☐

CAREGIVER HEALTH AND WELL-BEING

Overall caregiver physical health: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Overall caregiver emotional or mental health: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Conditions affecting the caregiver's ability to provide care: (check all that apply)

☐ Heart condition

☐ Arthritis/joint problems

☐ Loss of sleep

☐ Stress, anxiety, or depression

☐ Other: _____

HOUSEHOLD FINANCIAL INFORMATION

Income sources for all adults in the home: (check all that apply)

☐ Employment

☐ Social Security

☐ Family support

☐ Public assistance

☐ VA benefits

☐ Pension

☐ Rental income

☐ Retirement/investments

☐ Other: _____

Total annual household income for all adults before taxes:

☐ Less than \$10,000

☐ \$10,000-\$19,999

☐ \$20,000-\$29,999

☐ \$30,000-\$39,999

☐ \$40,000-\$49,999

☐ \$50,000 or more

Monthly income for person with dementia:

☐ Less than \$499

☐ \$500-\$999

☐ \$1,000-\$1,499

☐ \$1,500-\$1,999

☐ \$2,000-\$2,499

☐ \$2,500 or more

Difficulty paying for food, housing, utilities, and medical care:

☐ Not difficult

☐ A little difficult

☐ Somewhat difficult

☐ Very difficult

List monthly health and caregiving expenses and approximate costs (for example: prescriptions, incontinence products, in-home care, co-pays, etc.):

Item

Approximate Cost

ADULT DAY CARE SCHOLARSHIP

Complete this section only if requesting **Adult Day Care** assistance.

Currently attending a respite or adult day care center? ☐ No ☐ Yes

If yes, center name and days attended: _____

Why is adult day care requested? (check all that apply)

- ☐ Caregiver is employed ☐ Caregiver health ☐ Caregiver needs respite
☐ Person needs socialization/engagement ☐ Safety concerns
☐ Behavioral concerns ☐ Other: _____

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 alone	☐	☐	☐
Church, meetings, or community activities	☐	☐	☐
Hobbies or personal interests	☐	☐	☐
Meals or social activities outside the home	☐	☐	☐
Fun activities with other people	☐	☐	☐
Visits with family and friends	☐	☐	☐

CONTINENCE PRODUCTS SCHOLARSHIP

Complete this section only if requesting **Continence Products**.

Approximate monthly spending on continence products:

- ☐ \$0-\$50 ☐ \$51-\$100 ☐ \$101-\$150 ☐ \$151-\$200 ☐ More than \$200

Currently receives help obtaining continence products? ☐ No ☐ Yes

If yes, source:

- ☐ Hospice ☐ VA ☐ Alabama Cares ☐ Medicaid program
☐ Other: _____

NUTRITIONAL DRINKS SCHOLARSHIP

Complete this section only if requesting **Nutritional Drinks**.

Has a healthcare professional recommended a nutritional drink? ☐ Yes ☐ No

STATEMENT OF NEED

Please describe the family's circumstances. Emphasize financial need, caregiving challenges, and the need for formal support services. Tell us how these services would be helpful for the family and the person with dementia.

REFERRAL SOURCE (IF APPLICABLE)

Name: _____

Organization and title: _____

Telephone: _____ Email: _____

CONSENT AND CERTIFICATION

I certify that the information in this application is accurate and complete to the best of my knowledge. I understand that applying does not guarantee assistance and that a scholarship may be discontinued if information is found to be inaccurate or eligibility changes. I authorize Alzheimer's of Central Alabama to verify information relevant to eligibility and to share the minimum information necessary with its Scholarship Committee and approved providers for scholarship administration.

- ☐ I understand that I must notify ACA if the applicant's address, caregiver, service provider, income, benefits, or need for assistance changes.
- ☐ I understand that scholarships are subject to available funding, continued eligibility, and review.
- ☐ I confirm all applicable questions are answered, the requested program sections are complete, and the certification is signed.
- ☐ I would like to be added to the weekly ACA newsletter.

Printed name of primary caregiver: _____

Signature of primary caregiver: _____ Date: _____

Name of person living with dementia: _____

Return completed applications to Alzheimer's of Central Alabama by email aca@alzca.org or mail Alzheimer's of Central Alabama, PO Box 2273, Birmingham, AL 35201-2273.