DIOCESE OF PROVIDENCE
CATHOLIC SOCIAL SERVICES OF RI
ONE CATHEDRAL SQUARE
PROVIDENCE, RHODE ISLAND 02903-3695

(401) 421-7833
(401) 453-6135 FAX

Dear *CareBreaks* Applicant:

Catholic Social Services of RI has received your request for an application for *CareBreaks*, a respite program providing a break for caregivers caring for loved ones of any age.

We would like to help you continue to do this important work!

This is a cost share program; we pay part of the cost of a respite break and the cost to you is based on a sliding scale.

Please note that while providing proof of income is not mandatory, it will result in clients being listed in the highest cost share category (Level 4).

This packet includes an application with instructions and a list of frequently asked questions. Please read the instruction sheet carefully to complete the application correctly.

To ensure your application is processed within 14 business days, please be sure to fill out the entire application and to send along all required documentation (see application instructions) to the above address. Any missing information will delay your application from being processed. Once we have processed your application, we will notify you of our decision by mail.

If you have any questions during this process, please call our office at (401) 421-7833 x 212 or e-mail hmunoz@dioceseofprovidence.org.

Thank you for the important work that you do.

Sincerely,

Hector M. Munoz
Coordinator

Si tiene problema con esta aplicación, favor llamar al *CareBreaks*,
(401)421-7833 Extensión 212.
Se nao comprende este formulario, chame para *CareBreaks*,
(401)421-7833 Extensión

Enclosures *Rev 6/17/2019 hm*

Application Instructions

To avoid any delay in processing application, please complete the entire application and include appropriate documentation. Application must be signed by the caregiver or person submitting this application if not the caregiver.

SECTION 1 – COMPLETE FOR *CARE RECIPIENT* INFORMATION:

Date of Birth: Acceptable proof includes a copy of the care recipient's birth certificate, driver's license, or State ID card.

Medical Diagnosis: Give a brief description of the medical diagnosis in the space provided on the application.

Income Information: The amount of respite subsidy is based on the income of the care recipient and spouse, if applicable. For disable adult over the age of 18, the amount of respite subsidy is based on the income of adult care recipient and spouse, if applicable. For Children 18 and under subsidy is based on household income.

SECTION 2 - COMPLETE FOR *CAREGIVER* INFORMATION:

Proof of the primary caregiver's address must be included with this application. Acceptable proof includes a copy of the caregiver's current driver's license, State ID card or a utility bill.

Income Verification Requirements: All income must be reported and verified. Married couples living together must report and verify income of both spouses. Acceptable proof includes a copy of your most recent Income Tax Return, 1099 Statements, Social Security award letter, pension checks, and bank statements. Also include proof of interest, dividends, rental income, stocks and bonds. If your tax return does not list your Social Security income (Form 1040A line 13a or Form 1040 line 20a), you must send us a benefit award letter or bank statement proving how much Social Security you received in addition to the income reported on your tax return. Also include any paid medical expenses.

Medical Expenses: Paid medical expenses that exceed 3% of your income may entitle you to a Medical Expense Deduction (MED). A MED can reduce your countable income and reduce your share of cost. Individuals applying on the basis of the last calendar year's income may report medical expenses paid during the previous 12 months prior to the month of application, or the previous 90 days if there have been significant changes to their income.

Medical expenses include paid bills from physicians, dentists, vision and hearing specialists and other health care professionals, medical insurance including Medicare premiums and deductibles, ambulatory health care facilities, prescription medicines, institutional care, dental, vision and hearing devices, prosthetic and auxiliary apparatus. Proof of ***claimed medical expenses*** must be included with your application. Acceptable proof includes copies of paid receipts from your health insurance plan, receipts or print-outs of paid pharmacy bills or any other paid medical bills.

CareBreaks

"Providing a respite break for caregivers caring for their loved ones."

Application

Section 1 - Care Recipient Information

These questions are about the person who is cared for.

A.

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____/_____/_____

Proof of DOB is required. See instructions (page 2).

Gender: ☐ Male ☐ Female

Is the care recipient a veteran? ☐ Yes ☐ No Receiving Veteran Benefits ☐ NA

Is or was the care recipient married to a veteran? ☐ Yes ☐ No

Primary language spoken by the care recipient:

☐ English ☐ Portuguese

☐ Spanish ☐ Other_____

Medical Diagnosis/Disability (*See Instructions on page 2)*

_____

_____

B. Completing the following **care recipient's** information does **not** affect eligibility for services. This information is for statistical purposes only.

Care Recipient Demographics

Marital Status
- ☐ Married
- ☐ Widowed
- ☐ Single/Never Married
- ☐ Divorced
- ☐ Separated

Living Arrangement
- ☐ Alone
- ☐ With spouse only
- ☐ With spouse & other relatives
- ☐ With other relatives
- ☐ With non-relative
- ☐ Living with parent

Relationship to caregiver
- ☐ Wife
- ☐ Husband
- ☐ Daughter/(Daughter-in-law)
- ☐ Son/ (Son-in-law)
- ☐ Mother
- ☐ Father
- ☐ Other relative
- ☐ Non-relative
- ☐ Other _____

Employment
- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Other_____

Annual Household Income
- ☐ Under $8,000
- ☐ $8,000 - $11,999
- ☐ $12,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ Over $40,000

Education
- ☐ 8th Grade or less
- ☐ High School Diploma
- ☐ Some College
- ☐ Specialized Training
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Attending School_____
- ☐ Other_____

Race/Ethnicity (check all that apply)
- ☐ White, non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other_____

Section 2 - Caregiver Information

A.*These questions are about the **caregiver** - The person who does the caring.*
Additional instructions on page 2

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell phone: _____

Email: _____ Date of Birth: _____/_____/_____

Gender: □ Male □ Female Are you a veteran? □ Yes □ No

Number of hours the caregiver spends providing care in an average week: _____

What will this break allow you to do: _____

_____

How did you learn about CareBreaks? _____

Type of services I'm interested in for the care recipient:

Type of services I'm interested in for the care recipient:

□ In-home hourly care
□ Temporary overnight care
□ Combination of services
□ Adult day care
□ Special Childcare/Respite
□ Companion visit
□ Supervised, trained nursing student
□ Child Activity Program
□ I need more information about choices:_____
□ Other

Are you receiving any services now?
Yes – NO If yes, what service(s) _____ Agency/Program _____

Regular Care Provided by Caregiver

B. As the caregiver for this individual, I regularly (daily/weekly) assist him/her with the following: (check all that apply)

Basic Activities of Daily Living

- ☐ Personal hygiene bathing/grooming
- ☐ Feeding
- ☐ Dressing and undressing
- ☐ Toileting
- ☐ Bowel and bladder management – including incontinence care
- ☐ Transferring/walking (moving from bed to wheelchair, getting on and off toilet)

Inability of Care Recipient to perform

- ☐ Housework
- ☐ Meal preparation
- ☐ Medication management
- ☐ Shopping
- ☐ Money management
- ☐ Transportation
- ☐ Using the telephone and other communication devises

Special Health Care

- ☐ Medical equipment (oxygen, feeding tube, respiratory equipment, etc.)
- ☐ Medication (prescribed, ongoing)
- ☐ Nursing assistance (visits regularly)
- ☐ Diabetes (insulin dependent/special diet)
- ☐ Use of wheelchair, cane, crutches, braces, or walker
- ☐ Incontinence - How often? _____
- ☐ Other specialized care needs_____

Care Recipient has difficulty

- ☐ Seeing
- ☐ Communicating
- ☐ Hearing
- ☐ Comprehending

The Care Recipient has the following specific conditions

- ☐ Aggressiveness
- ☐ Withdrawn
- ☐ Acting out/impulsive
- ☐ Alzheimer's or dementia
- ☐ Seizures – Type_____ Date of last Seizure_____

Homebound (cannot leave home without considerable assistance) ☐Yes ☐ No

Caregiver Demographics

C. Completing the following caregiver information does not affect eligibility for service. This information is for statistical purposes only.

Marital Status
- ☐ Married
- ☐ Widowed
- ☐ Never Married
- ☐ Divorced
- ☐ Separated

Relationship to Care Recipient
- ☐ Wife
- ☐ Husband
- ☐ Daughter(Daughter-in-law)
- ☐ Son (Son-in-law)
- ☐ Mother
- ☐ Father
- ☐ Non-relative
- ☐ Other relative
- ☐ Other

Employment
- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Unemployed
- ☐ Other_____

Annual Household Income
- ☐ $8,000 - $11,999
- ☐ $12,000 - $14,999
- ☐ $15,000 - $19,999
- ☐ $20,000 - $29,999
- ☐ $30,000 - $39,999
- ☐ Over $40,000

Education
- ☐ 8th Grade or less
- ☐ High School Diploma
- ☐ Some College
- ☐ Specialized Training
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Other_____

Race/Ethnicity (check all that apply)
- ☐ White, non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other_____

Section 3 - Income Information

If applying ONLY for the companion or student nurse program, go to page 10

In order to determine our level of cost sharing please…
Complete Section A. If you are caring for disabled adult any age over 18, a senior 60 plus, or Alzheimer's of any age.

In the appropriate box list **all** Income – Taxable and non-taxable
(Married couples must report their combined income)

Please check one: Income below, is from the past **Year___** or **90 Days___**

Section A. Care Recipient Income Information for adults 18 and older

Social Security	**$**
Other Pension	**$**
Employment (Wages)	**$**
Rental Income	**$**
Interest/ Dividends	**$**
Other Income	**$**

Total $ _____

Declare all income for either an individual or for both spouses if a married couple. Income includes social security, pensions, and wages from employment, interest and dividends, rental income from property, revenue from stocks.

In order to determine our level of cost sharing please…
Complete Section B. If you are caring for a child under the age of 18

Please check one: Household Income is from the past **Year___** or **90 Days___**

Section B: Care Recipient Income Information for those Under 18 years old

Federally Adjusted Gross Income (As reported annually to the IRS)	$
Social Security, SSI, SSDI (if not reported on tax return)	$
Other Income (If not reported on tax return)	$

Total $_____

Section C – Medical Expenses

Please refer to the *Medical Expenses* portion of the *Application Instructions* for details on eligible medical expenses.

No matter which of the above Income Information sections you filled out, please include information about your medical expenses, if applicable. By submitting your Medical expenses, we may be able to reduce your cost share.

Medical Expenses – Please enter the amount medical expenses paid over the past (choose one)

Year $_____ OR 90 Days_____

Your application is complete if you have included the following

- ✓ **Income verification**
  (Except Companion or Nursing Student Program)
- ✓ Proof of primary caregiver's address
- ✓ Proof of Care Recipient's age
- ✓ Medical expense verification (if any)
  (Except Companion or Nursing Student Program)

Please send completed applications to:

CareBreaks Program
Catholic Social Services of RI
One Cathedral Square
Providence, RI 02903-3695

I certify, under penalty of perjury, that the information provide in this application is true and accurate.

Signature of Caregiver: _____ **Date:** _____

_____ Date: _____
Signature of person completing this form if different from caregiver