

Lifespan Respite Application

Caregiver Information

Full Name:		Date of Birth:	
Address:			
Email:		Phone:	
Gender:		Race:	
Ethnicity			
Gross annual income:			
Highest level of education:	☐ High School/GED	☐ Post-Secondary	
	☐ Trade/Vocational	☐ Prefer not to answer	
Are you a Veteran?	☐ Yes	☐ No	
	☐ Prefer not to answer		

Care Recipient Information

Full Name:		Date of Birth:	
Address:			
Email:		Phone:	
Gender:		Race:	
Ethnicity			
Does this person need care/supervision most of the time?			
Highest level of education:	☐ High School/GED	☐ Post-Secondary	
	☐ Trade/Vocational	☐ Prefer not to answer	
Are you a Veteran?	☐ Yes	☐ No	
	☐ Prefer not to answer		

Respite Benefits:

Are you or your loved one currently receiving respite services from any of these programs?

Arizona Long Term Care (ALTCs)	☐	Yes	☐	No	☐	Unknown
Area Agency on Aging (AAA)	☐	Yes	☐	No	☐	Unknown
Hospice (Medicare Benefit) in a Facility	☐	Yes	☐	No	☐	Unknown
Veteran's Administration (VA)	☐	Yes	☐	No	☐	Unknown
Developmental Disability Services	☐	Yes	☐	No	☐	Unknown
Other State/Federal Respite Program	☐	Yes	☐	No	☐	Unknown
I pay for respite myself	☐	Yes	☐	No	☐	Unknown

Do you provide assistance with more than two activities of daily living (ADLs)? For example, eating, dressing, mobility/transferring or toileting.

☐ Yes ☐ No

For children: Do they require special care beyond regular parenting?

☐ Yes ☐ No

Is there any additional information you'd like to share?

Program

Program Applying For: ☐ Care Program (\$599 or \$2400) ☐ Partners Program

Have you received respite from ACC before?

How did you hear about us?

Caregiver Assessment Tool (CAT)

Caregivers are often so concerned with caring for their loved ones needs that they lose sight of their own well-being. Please take a moment to answer the following questions about you.

What is your...

Medical status? ☐ **Good** ☐ **Fair** ☐ **Poor**

Emotional status? ☐ **Good** ☐ **Fair** ☐ **Poor**

In the past three months, have you...

3.1 Felt cut off from family/friends? ☐ **Yes** ☐ **No**

3.2 Felt overwhelmed? ☐ **Yes** ☐ **No**

3.3 Had trouble falling asleep, staying asleep or waking up too early? ☐ **Yes** ☐ **No**

3.4 Noticed your eating habits worsening as a result of caregiving? ☐ **Yes** ☐ **No**

3.5 Been frustrated or angry? ☐ **Yes** ☐ **No**

3.6 Often felt sad or depressed? ☐ **Yes** ☐ **No**

3.7 Often felt nervous or anxious? ☐ **Yes** ☐ **No**

3.8 Had crying spells or felt like you needed to cry? ☐ **Yes** ☐ **No**

What is your relationship to the care recipient?

How long have you been providing care?

Caregiver Assessment Tool (CAT) Cont.

What health conditions
are affecting you?

On a scale of 1 to 10, with
one being "not stressful"
and 10 being "extremely
stressed", please rate
your current level of
distress:

4.5 In the past six months, do you feel your satisfaction with the help and support you received from others has increased, declined or stayed the same?

- a.
- b.
- c.
- d.
- e.
- f.
- g.

5.1 In the past month, how often have you been able to spend time on activities that you enjoy?

- a.
- b.
- c.
- d.
- e.

5.2 How satisfied are you with the overall amount of time you have been able to spend on the activities that you enjoy?

- a.
- b.
- c.
- d.
- e.

5.3 In the past six months, do you feel your satisfaction with the overall amount of time you have been able to spend on pleasurable activities has increased, declined or stayed the same?

- a.
- b.
- c.
- d.
- e.
- f.
- g.

Please read carefully and mark each item after reading:

1. Completion of this application does not guarantee that I will be eligible for the Respite Program(s).
2. Caregiver agrees to complete application in its entirety, including an exit interview upon completion of services.
3. Caregiver is responsible for any balance due if hours or funds are exceeded.
4. I authorize the Arizona Caregiver Coalition to share personal information on behalf of myself and the care recipient for the purpose of coordinating supportive care, managing billing, and contributing to advocacy or research efforts.
5. I understand that ACC will take necessary precautions to maintain confidentiality. If I have any concerns about my privacy or personal information, I will contact ACC immediately.

My Signature on this form signifies that all information provided on this form and during any other assessments conducted by the Arizona Caregiver Coalition and the Caregiver Resource Line is truthful and accurate.

.....
Printed Name

.....
Signature

.....
Date



Next Steps:

You can upload your supporting documentation and this application by:

- Email: info@azcaregiver.org, subject "Last Name, First Name Application"
- Mail: Arizona Caregiver Coalition, PO Box 21623, Phoenix AZ 85036
- Fax: (8888) 737-7494

A staff member will review your application upon receipt. Processing may take up to four weeks, and staff may contact you at the above information for clarification or questions.