Kansas Respite for Alzheimer's & Dementia Program (K-RAD)

APPLICATION

Section 1: CARE RECIPIENT INFORMATION

Name: _____ **DOB :** _____ **Gender:** ☐ Male ☐ Female

Home Address: _____

Street / PO Box City Zip County

Care Recipient Race/Ethnicity: ☐ Native American or Alaska Native ☐ Hispanic or Latino ☐ Asian or Asian American ☐ Black or African American ☐ White/Caucasian ☐ Native Hawaiian or Pacific Islander ☐ Other/Unknown:

Diagnosis of Care Recipient: _____
(Attach documentation to support diagnosis - Medical Certification Form)

Section 2 : PRIMARY CAREGIVER INFORMATION

Name: _____ **Gender:** ☐ Male ☐ Female

Age: ☐ 18 -39 ☐ 40-59 ☐ 60-75 ☐ 76+ **Primary Email:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Home Address ☐ Same as Care Recipient (If different, KDADS must review)

_____

Street / PO Box City Zip County

Caregiver Race/Ethnicity: ☐ Native American or Alaska Native ☐ Hispanic or Latino ☐ Asian or Asian American ☐ Black or African American ☐ White/Caucasian ☐ Native Hawaiian or Pacific Islander ☐ Other/Unknown:

Caregiver's relationship to the Care Recipient is: ☐ Friend ☐ Legal Guardian ☐ Partner ☐ Sibling ☐ Power of Attorney ☐ Daughter/Son (in-law) ☐ Grandchild ☐ Spouse ☐ Other

Time spent caregiving each week: ☐ Less than 5 Hours ☐ 5–10 Hours ☐ 11–20 Hours ☐ 20–40 Hours ☐ 40+ Hours ☐ Full-Time 24/7

How "stressed" are you as a result of caring for the care recipient: ☐ Not at all stressed ☐ Slightly stressed ☐ Moderately stressed ☐ Very stressed ☐ Extremely stressed

Health of Primary Caregiver at time of request (check one): ☐ Good ☐ Fair ☐ Poor ☐ Critical

Section 3: AGREEMENT AND SIGNATURE

Please read the following carefully and initial each to show your understanding:

I am the Primary Caregiver of the Care Recipient listed in this application form, and I wish to enroll in the Kansas Respite for Alzheimer's and Dementia Program (K-RAD). I attest that I meet all eligibility requirements. I understand that funding is not guaranteed, but based on a first-come-first-served basis until funds are depleted, and that funds are only to be used for respite services.

I understand that I must provide the acceptable documentation of the Care Recipient's probable diagnosis with this application form.

I understand and acknowledge that I am responsible for hiring a respite provider organization from the list provided to me by the AAA and that I am responsible for any difference in the amount approved $1,000 and the amount used, if any.

I understand that information provided on this form may be checked, and if I have given false statements or information, I may be found guilty of fraud. Fraudulent activity will result in 100% repayment of funding and inability to utilize K-RAD Program in the future.

I agree to the above conditions and that funds will be used ONLY for respite care .

Signature of Caregiver Date:

_____ _____