



2024 Caregiver's Conference Respite Application

Caregiver Name _____

Address: _____

Daytime phone: _____ Email: _____

DOB of Caregiver: _____

Gender of Caregiver: Male Female Other Do not want to provide

Name of Individual you provide care for: _____

Address (if living in a different location): _____

DOB of individual you are caring for: _____

Gender of Individual you are caring for: Male Female Other Do not want to provide

Length of time you have been caring for this person: _____ (in years and months)

How many hours do you usually spend providing care for this individual? _____ Day ____ Week

Number of Respite Hours Requested _____

Cognition:	Yes	No
Individual demonstrates symptoms of dementia or has been diagnosed with dementia	<input type="checkbox"/>	<input type="checkbox"/>
It is no longer safe for the individual to be left alone.	<input type="checkbox"/>	<input type="checkbox"/>
The individual is no longer able to follow through with reminders or prompts.	<input type="checkbox"/>	<input type="checkbox"/>

How many hours each day can the individual **safely** be left alone? _____ Hours

Level of Care/Assistance	None	1	2 or more
The level of care my loved one requires with activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activities of Daily Living include: dressing, bathing, transferring, etc.

Are there any other things that we should know (anything that was not captured here that indicates that you would not be able to attend the Caregiver Conference without a subsidy that you would like to make us aware?)

Completed applications will be reviewed by the coalition, applicants will be contacted by email or phone of the coalition's decision.

Respite funds will be issued after the conference.

Ellen M. Edgerly

Ellen M. Edgerly, Chair

Coalition of Caring Planning Committee

Brain Injury Association of New Hampshire

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