SOUTH CAROLINA
Family Caregiver
Support Program

UPPER SAVANNAH
Council of Governments

Greetings,

Thank you for your interest in the Upper Savannah Family Caregiver Support Program. Below are some guidelines to keep in mind when completing the intake form.

1) The respite voucher is specifically for **FAMILY CAREGIVERS** to receive respite or a temporary break. It does not provide additional services for the care receiver. The **FAMILY CAREGIVER** is considered the client.

2) The caregiver on the intake form should be family member or other caretaker (friend, neighbor, extended relative, etc.) who provides consistent, hands-on care and is in need of a break.

3) Caregivers or care receivers receiving respite services through the South Carolina Respite Coalition are **NOT** eligible to apply for the Upper Savannah Family Caregiver Support Program. We cannot duplicate services with this agency.

4) Caregivers or care receivers receiving respite services through CLTC, Veterans Administration Aid and Attendance, or Hospice Facility Respite **MAY** complete the intake form, but approval will be based on current funding levels. Receiving other services is a factor when determining priority.

5) Intake forms are screened for eligibility. Everyone who fills out the intake form will not receive funding. Caregivers will receive written notification of ineligibility.

6) The respite voucher must be utilized by a DPH-licensed agency. We do **NOT** pay private sitters, caregivers, or family members of the care receiver or caregiver.

7) We are **NOT** an emergency service. The intake and assessment process takes time and wait times vary throughout the year based on funding levels and request volume.

8) We cannot accept intake forms completed by care providers who benefit financially from the respite voucher. This is a conflict of interest.

9) Please write in legible print to be considered. Any illegible information will increase wait time.

10) Once your intake form is completed, our staff will call you to conduct the required phone interview with the caregiver listed on the form. We process intakes in the order they are received. **Thank you for your understanding and patience regarding the wait time for your interview and grant.**

Please feel free to call our Information and Referral Specialist with any questions regarding other programs or services offered by the Upper Savannah Area Agency on Aging at **864-941-8050.**

Thank you,

Aeriell Bowick

Aeriell Bowick
Family Caregiver Advocate
Upper Savannah Area Agency on Aging
430 Helix Road
Greenwood, SC 29649
864-941-8067
Abowick@uppersavannah.com

CHECKLIST FOR CAREGIVER(S)

KEEP THIS PAGE FOR YOUR RECORDS. DO NOT RETURN.

FILL OUT AND RETURN THE 4-PAGE INTAKE FORM (AND DIAGNOSIS FORM IF REQUIRED)

- ☐ COMPLETE PHONE INTERVIEW WITH AERIELL BOWICK, THE FAMILY CAREGIVER ADVOCATE (THESE ARE COMPLETED IN THE ORDER IN WHICH THEY ARE RECEIVED)
- ☐ CHOOSE AN AGENCY FROM THE LIST PROVIDED TO YOU AFTER THE PHONE INTERVIEW (IF APPROVED FOR A VOUCHER, THIS LIST WILL BE SENT TO YOU)
- ☐ LET AERIELL BOWICK, THE FAMILY CAREGIVER ADVOCATE, KNOW WHICH AGENCY YOU WANT TO USE (THIS IS WHEN THE VOUCHER WILL BE SENT TO THE AGENCY OF YOUR CHOICE)
- ☐ ONCE A VOUCHER IS SENT, THE AGENCY YOU CHOSE SHOULD CONTACT YOU TO START SETTING UP A SCHEDULE TO START PROVIDING SERVICE TO YOUR LOVED ONE. (IF YOU DO NOT HEAR FROM THE AGENCY WITHIN 3-5 DAYS OF VOUCHER BEING SENT- CONTACT THE AGENCY)

REMINDERS

- YOU CAN REAPPLY FOR A VOUCHER EVERY YEAR - THERE IS NO GUARANTEE YOU WILL BE APPROVED, BUT YOU CAN REAPPLY YEARLY.
- UPPER SAVANNAH COUNCIL OF GOVERNMENTS IS NOT RESPONSIBLE FOR ANY SERVICES PROVIDED BY AN AGENCY BEFORE THE VOUCHER HAS BEEN APPROVED AND SENT.
- UPPER SAVANNAH COUNCIL OF GOVERNMENTS IS NOT ABLE TO PROVIDE EMERGENCY PLACEMENT.
- THE VOUCHER MUST BE USED WITHIN 90 DAYS OF THE APPROVAL DATE.

BLACKOUT DATES

PLEASE BE AWARE OF OUR BLACKOUT DATES IN JUNE. WE WILL NOT BE RESPONSIBLE FOR PROVIDING SERVICES DURING THE TIME OF **JUNE 10TH – JUNE 30TH**. WE WILL RESTART SERVICES ON JULY 1ST.

THIS BLACKOUT TIME FRAME ALLOWS US TO RECEIVE ANY OUTSTANDING INVOICES FROM ALL THE AGENCIES AND GET THEM ENTERED INTO OUR SYSTEM BEFORE OUR NEW FISCAL YEAR STARTS ON JULY 1ST.

WE APOLOGIZE FOR ANY INCONVENIENCE THIS MAY CAUSE.

FAMILY CAREGIVER SUPPORT PROGRAM: INTAKE FORM - ELIGIBILITY

FISCAL YEAR _____ #_____

ATTENTION: This form MUST be completed by the caregiver listed on the intake form. It is NOT appropriate for a medical professional, social worker, case manager, or any other person to fill out this form on behalf of a client/caregiver.

Caregiver: _____ Care Receiver: _____

The Family Caregiver Support Program offers caregivers a chance to receive much-needed respite and other support services. It is a program funded under the Older Americans Act, through Federal and State funding. To be eligible, the care receiver must have substantial deficits in their activities of daily living or have a medical diagnosis of Alzheimer's, dementia, or related disorder. Please see the Alzheimer's/ Dementia Diagnosis Form if applicable.

Due to **cognitive or other mental impairment**, does the care receiver require substantial supervision to maintain their health and safety? ☐ Yes ☐ No

Significant Health Problems, Recent Hospitalizations, Significant Diagnosis:

_____

_____

_____

Is the care receiver currently receiving services from:

☐ CLTC (Medicaid) ☐ Hospice ☐ SC Respite Coalition

☐ VA Aid & Attendance ☐ Home Health ☐ Paid Out of Pocket

The caregiver is a:

☐ New Client ☐ Returning Client

Caregiver Demographics	Date

Caregiver Information

Introductory Information

First Name	M.I.	Last Name	Are you a Paid Caregiver? ☐ Yes ☐ No
Physical Address			Apt
City	State	Zip	County
Primary Phone	Secondary Phone		Internet ☐ Yes ☐ No
Age	DOB mm/dd/yyyy	Email	

Demographics

Gender
☐ Female ☐ Male ☐ Other ☐ Decline

Ethnicity
☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Declined

Marital Status
☐ Married ☐ Widowed ☐ Divorced
☐ Single ☐ Domestic Partner/Civil Union

Race
☐ American Indian/ Alaska Native ☐ Asian/Asian American
☐ Native Hawaiian/Pacific Islander ☐ Black/African American
☐ White ☐ Declined ☐ Other:_____

Number in Household
_____

Monthly Household Income
☐ $_____ ☐ Decline

Caregiver's Relationship to Care Recipient

☐ Husband ☐ Wife ☐ Domestic Partner/Civil Union ☐ Daughter/Daughter-in-law ☐ Son/Son-in-law
☐ Sister ☐ Brother ☐ Grandparent ☐ Parent ☐ Other Relative ☐ Non-Relative

Care Recipient Condition

Does the care receiver have a condition that causes limitations in activities? ☐ Yes ☐ No

☐ ADRD (Alzheimer's/Dementia Related Disease) ☐ Intellectual Disability ☐ Physical Condition ☐ Cognitive/Behavior Condition
☐ Wandering ☐ Total Care ☐ Other Condition ☐ Disabled Adult ☐ None

Has the care receiver been diagnosed, by a physician, to have Alzheimer's or a related dementia? ☐ Yes ☐ No

Care Recipient Information (on next page)

Care Recipient Information

First Name	M.I.	Last Name

Physical Address	Apt

City	State	Zip	County

Primary Phone	Secondary Phone	Internet
		☐ Yes ☐ No

Age	DOB mm/dd/yyyy	Email

Care Recipient Demographics

Gender
☐ Female ☐ Male ☐ Other ☐ Decline

Ethnicity
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Marital Status
☐ Married ☐ Widowed ☐ Divorced
☐ Single ☐ Domestic Partner/Civil Union

Race
☐ American Indian/ Alaska Native ☐ Asian/Asian American
☐ Native Hawaiian/Pacific Islander ☐ Black/African American
☐ White ☐ Declined ☐ Other:_____

Military Service
☐ Retired Military ☐ History of Military Service ☐ Never Served ☐ Spouse/Widow(er) of Veteran ☐ Declined

Referred by:

_____

(Name) **(Agency/Organization)** **(Phone Number)**

Family Caregiver Support Program: Intake Form - Release of Information

Caregiver's Name: _____

Address: _____

Phone Number: _____

Care Receiver's Name: _____

Address: _____

Phone Number: _____

This form grants permission to the Upper Savannah Family Caregiver Support Program to release or obtain information about the services we are requesting. In granting this permission, I understand that the information will remain confidential to all parties not directly involved in helping me obtain the services I am requesting and that this information will be used only to provide support and services.

I understand that Upper Savannah Family Caregiver Support Program is not responsible for the hiring, wages, work performance, quality of care, or conduct of the caregiver or the provider agency for the services I request or receive. The Upper Savannah Family Caregiver Support Program does not assume any liability for acts or omissions of the caregiver or the provider of the services. I understand that by giving my consent and releasing this information, I am releasing the Upper Savannah Family Caregiver Support Program from any and all liabilities potentially associated with the services I am requesting or receive.

I certify that all information provided to the Upper Savannah Family Caregiver Support Program is correct to the best of my knowledge.

I pledge to promptly notify Upper Savannah Family Caregiver Support Services of any changes in situation, such as major health changes, hospitalizations, changes of address or phone number, change in respite provider, or benefits received through other programs such as Community Long Term Care, Veterans Administration Aid and Attendance, or Hospice Facility Respite.

Signature of Caregiver: _____

Date of Signature: _____

(Signature Is Required to Receive Services)