Seniors Raising Children Application

Today's Date_____

CAREGIVER INFORMATION				
Last Name:		First Name:		
Address:		Telephone: Type text here		
Date of Birth: / /	Gender: M_____F_____	Monthly Household Income:	Race:	Marital Status:
Number of people in household:				

Please note the following requirements for our program. You must meet all criteria and provide all documents in order to receive assistance.

1.) Children must be under the age of 18 to qualify.
2.) Children must live in your home.
3.) Parent of child must **not** be residing in the home.
4.) Senior must provide copy of South Carolina Photo issued ID with home address listed.
5.) Senior must provide supporting documentation from educational institute or approved agency that verifies the home address(es) of minor(s).

INFORMATION OF CHILD			
Last Name:		First Name:	
What is your relation to the child?			
Date of Birth: / /	Gender: M_____F____	Race:	Grade:
Greatest Need:			

Please check all current services child receives:

Medicaid ❑ VA ❑ Medicare ❑ SNAP ❑ TANF ❑

Child Support Father ❑ Child Support Mother ❑ Social Security Benefits ❑

Upper Savannah Council of Government- Area Agency On Aging
430 Helix Rd, Greenwood, SC 29646
Phone: 864-941-8067 Email: abowick@uppersavannah.com

SRC Participation Agreement Form

Please read this carefully as it is an agreement between you and the Family Caregiver Support Program which may have an impact on any financial support you may receive from the program.

1. I confirm that I am primarily responsible for the children listed on this application.

2. I certify that all of the information provided to the FCSP staff is accurate to the best of my knowledge.

3. I understand that the parent(s) of the child(ren) are not allowed to live in the home with the child(ren).

4. I will inform FCSP staff of any changes to: address, phone number (including cell) of any and all participants in this program.

5. I understand that I must receive authorization for services from the FCSP before any funds can be dispersed.

As the FCSP is a consumer directed program, you may be requested to participate in interviews or surveys to measure client satisfaction and the effectiveness of the program. Should you not wish to participate, it will not affect your eligibility for the program or its benefits.

CONSENT TO RELEASE INFORMATION

The information on this form is required by the local provider, the Area Agency on Aging (AAA), the South Carolina Department on Aging and the U. S. Federal Government. The information provided will be kept confidential and guarded against unofficial use.

Some of the information gathered may be used to refer or provide appropriate services for client (such as referral for other services, emergency contact or sharing pertinent information to related service agencies for the purposes of planning services to meet the needs of the client.)

Some of the data asked for is required by either the South Carolina Department on Aging and/or the U. S. Federal Government, as entities funding the services, and will be used for reporting and research. This data will not include the client's name or identifying information and is aggregated. A client has the right to REFUSE to provide information. However, by refusing to answer particular questions, the client may be waiving his/her right to receive certain services.

Senior's Signature: _____ Date: _____

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INFORMATION OF CHILD			
Last Name:		First Name:	
What is your relation to the child?			
Date of Birth: / /	Gender: M_____F____	Race:	Grade:
Greatest Need:			
Please check all current services child receives: Medicaid ❑ VA ❑ Medicare ❑ SNAP ❑ TANF ❑ Child Support Father ❑ Child Support Mother ❑ Social Security Benefits ❑			

INFORMATION OF CHILD			
Last Name:		First Name:	
What is your relation to the child?			
Date of Birth: / /	Gender: M_____F____	Race:	Grade:
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Please check all current services child receives: Medicaid ❑ VA ❑ Medicare ❑ SNAP ❑ TANF ❑ Child Support Father ❑ Child Support Mother ❑ Social Security Benefits ❑			

SRC Questionnaire

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Please circle or list all answers to the following questions:

1. **Are you currently employed? FULL TIME PART TIME NOT EMPLOYED RETIRED**
2. **How long have you been caring for child(ren) YEARS _____ MONTHS _____.**
3. **Does the child(ren) have any disabilities (physical, cognitive, learning, sensory, etc)?**

   _____

   _____
4. **Is there anyone else that provides care for the child(ren)? YES NO**

   IF SO WHOM_____
5. **Is the child(ren) currently involved in any after school sports or academic programs?**

   YES NO IF YES PLEASE LIST or IF NO PLEASE STATE WHY:

   _____

   _____
6. **How would you rate your emotional well-being? EXCELLENT GOOD FAIR POOR**
7. **Do you feel disconnected from child(ren) or feel it is difficult to communicate with child(ren)? YES NO**
8. **Please briefly describe circumstances that lead to your involvement of raising child(ren):**

   _____

   _____

   _____

   _____

   _____

   _____