



ROMAN CATHOLIC DIOCESE *of* PROVIDENCE

ONE CATHEDRAL SQUARE
PROVIDENCE, RHODE ISLAND 02903-3695
401-421-7833 – 401-453-6135 fax

CATHOLIC SOCIAL
SERVICES OF RI



Dear *CareBreaks* Applicant:

Community Services and Catholic Charities of the Diocese of Providence, has received your request for an application for *CareBreaks*, a respite program providing a break for caregivers caring for loved ones of any age.

We would like to help you continue to do this important work!

This is a cost share program; we pay part of the cost of a respite break and the cost to you is based on a sliding scale.

Please note that while providing proof of income is not mandatory, it will result in clients being listed in the highest cost share category (Level 4).

This packet includes an application with instructions and a list of frequently asked questions. Please read the instruction sheet carefully to complete the application correctly.

To ensure your application is processed within 14 business days, please be sure to fill out the entire application and to send along all required documentation (see application instructions) to the above address. Any missing information will delay your application from being processed. Once we have processed your application, we will notify you of our decision by mail.

If you have any questions during this process, please call our office at (401) 421-7833 x 212 or email hmunoz@dioceseofprovidence.org.

Thank you for the important work that you do.

Sincerely,
Hector M. Munoz
Coordinator

Si tiene problema con esta aplicación, favor llamar al *CareBreaks*,
(401)421-7833 Extensión 212/202.

Se nao comprende este formulario, chame para *CareBreaks*,
(401)421-7833 Extensión 212/202

Enclosures

The *CareBreaks* program is administered by Catholic Social Services of RI of the Diocese of Providence, funded in part with federal and state funding through the RI Office of Healthy Aging

Rev 1/20/2023

*Aids Ministry · Bishop Tobin's "Keep the Heat On" · Catholic Campaign for Human Development · Community Advocacy
Elder Services · Emmanuel House · Health Care Ministry · Immigration & Refugee Services · Interfaith Dire Emergency Fund
Justice & Peace Education · Multi-Cultural Ministry · Prison Ministry · Project Hope/Proyecto Esperanza*

Application Instructions

To avoid any delay in processing application, please complete the entire application and include appropriate documentation. Application must be signed by the caregiver or person submitting this application if not the caregiver.

SECTION 1 - COMPLETE FOR CARE RECIPIENT INFORMATION:

Date of Birth: Acceptable proof includes a copy of the care recipient's birth certificate, driver's license, or State ID card.

Medical Diagnosis: Give a brief description of the medical diagnosis in the space provided on the application.

Income Information: The amount of respite subsidy is based on the income of the care recipient and spouse, if applicable. For disable adult over the age of 18, the amount of respite subsidy is based on the income of adult care recipient and spouse, if applicable. For Children 18 and under subsidy is based on household income.

Income Verification Requirements: All income must be reported and verified. Married couples living together must report and verify income of both spouses. Acceptable proof includes a copy of your most recent Income Tax Return, 1099 Statements, Social Security award letter, pension checks, and bank statements. Also include proof of interest, dividends, rental income, stocks and bonds. If your tax return does not list your Social Security income (Form 1040A line 13a or Form 1040 (line 20a), you must send us a benefit award letter or bank statement proving how much Social Security you received in addition to the income reported on your tax return. Also include any paid medical expenses.

Medical Expenses: Paid medical expenses that exceed 3% of your income may entitle you to a Medical Expense Deduction (MED). A MED can reduce your countable income and reduce your share of cost. Individuals applying on the basis of the last calendar year's income may report medical expenses paid during the previous 12 months prior to the month of application, or the previous 90 days if there have been significant changes to their income.

Medical expenses include paid bills from physicians, dentists, vision and hearing specialists and other health care professionals, medical insurance including Medicare premiums and deductibles, ambulatory health care facilities, prescription medicines, institutional care, dental, vision and hearing devices, prosthetic and auxiliary apparatus. Proof of ***claimed medical expenses*** must be included with your application. Acceptable proof includes copies of paid receipts from your health insurance plan, receipts or print-outs of paid pharmacy bills or any other paid medical bills.

SECTION 2 - COMPLETE FOR CAREGIVER INFORMATION: Proof of the primary caregiver's address must be included with this application. Acceptable proof includes a copy of the caregiver's current driver's license, State ID card or a utility bill.

Application

SECTION 1

CARE RECIPIENT INFORMATION

A. These questions are about the person who is cared for.

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: ____/____/____

Gender: _____

Are you currently enrolled in Medicaid? ☐ Yes ☐ No

If no, are you in the process of applying for Medicaid? ☐ Yes ☐ No

Is the care recipient a veteran? ☐ Yes ☐ No

Is or was the care recipient married to a veteran? ☐ Yes ☐ No

Primary language spoken by the care recipient:

☐ English

☐ Portuguese

☐ Spanish

☐ Other _____

Medical Diagnosis/Disability (See Application Instructions): _____

B. Completing the following **care recipient's** information does NOT affect eligibility for services. This information is for statistical purposes only.

CARE RECIPIENT DEMOGRAPHICS

Marital Status

- ☐ Married
- ☐ Partnered, unmarried
- ☐ Widowed
- ☐ Single/Never Married
- ☐ Divorced
- ☐ Separated

Annual Household Income

- ☐ Under \$21,999
- ☐ \$22,000 - \$41,999
- ☐ \$42,000 - \$61,999
- ☐ \$62,000 - \$81,999
- ☐ \$82,000 - \$109,999
- ☐ Over \$110,000

Living Arrangement

- ☐ Alone
- ☐ With spouse only
- ☐ With spouse & other relatives
- ☐ With unmarried partner
- ☐ With other relatives
- ☐ With non-relative
- ☐ Living with parent

Education

- ☐ 8th Grade or less
- ☐ High School Diploma
- ☐ Some College
- ☐ Specialized Training
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Attending School _____
- ☐ Other _____

Relationship to caregiver

- ☐ Wife
- ☐ Husband
- ☐ Daughter/(Daughter-in-law)
- ☐ Son/ (Son-in-law)
- ☐ Mother
- ☐ Father
- ☐ Non-relative
- ☐ Other _____

Race/Ethnicity (check all that apply)

- ☐ White, non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other _____

Employment

- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Other _____

SECTION 2

CAREGIVER INFORMATION

A. *These questions are about the caregiver - The person who does the caring.*

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell phone: _____

Email: _____ Date of Birth: ____/____/____

Gender: _____ Are you a veteran? ☐ Yes ☐ No

Number of hours the caregiver spends providing care in an average week: _____

What will this break allow you to do: _____

How did you learn about CareBreaks? _____

Type of services I'm interested in for the care recipient:

Type of services I'm interested in for the care recipient:

- ☐ In-home hourly care
- ☐ Temporary overnight care
- ☐ Combination of services
- ☐ Adult day care
- ☐ Special Childcare/Respite
- ☐ Companion visit
- ☐ Supervised, trained nursing student
- ☐ Child Activity Program
- ☐ I need more information about choices: _____
- ☐ Other

Are you receiving any services now?

Yes - NO If yes, what service(s) _____ Agency/Program _____

REGULAR CARE PROVIDED BY CAREGIVER

B. As the caregiver for this individual, I regularly (daily/weekly) assist with the following: (check all that apply)

Basic Activities of Daily Living

- ☐ Personal hygiene bathing/grooming
- ☐ Feeding
- ☐ Dressing and undressing
- ☐ Toileting
- ☐ Bowel and bladder management - including incontinence care
- ☐ Transferring/walking (moving from bed to wheelchair, getting on and off toilet)

Inability of Care Recipient to perform

- ☐ Housework
- ☐ Meal preparation
- ☐ Medication management
- ☐ Shopping
- ☐ Money management
- ☐ Transportation
- ☐ Using the telephone and other communication devices

Special Health Care

- ☐ Medical equipment (oxygen, feeding tube, respiratory equipment, etc.)
- ☐ Medication (prescribed, ongoing)
- ☐ Nursing assistance (visits regularly)
- ☐ Diabetes (insulin dependent/special diet)
- ☐ Use of wheelchair, cane, crutches, braces, or walker
- ☐ Incontinence - How often? _____
- ☐ Other specialized care needs _____

Care Recipient has difficulty

- ☐ Seeing
- ☐ Communicating
- ☐ Hearing
- ☐ Comprehending

The Care Recipient has the following specific conditions

- ☐ Aggressiveness
- ☐ Withdrawn
- ☐ Acting out/impulsive
- ☐ Alzheimer's or dementia
- ☐ Seizures - Type _____ Date of last Seizure _____

Homebound (cannot leave home without considerable assistance) ☐ Yes ☐ No

CAREGIVER DEMOGRAPHICS

C. Completing the following caregiver information does NOT affect eligibility for service. This information is for statistical purposes only.

Marital Status

- ☐ Married
- ☐ Partnered, unmarried
- ☐ Widowed
- ☐ Never Married
- ☐ Divorced
- ☐ Separated

Annual Household Income

- ☐ Under \$21,999
- ☐ \$22,000 - \$41,999
- ☐ \$42,000 - \$61,999
- ☐ \$62,000 - \$81,999
- ☐ \$82,000 - \$109,999
- ☐ Over \$110,000

Relationship to Care Recipient

- ☐ Wife
- ☐ Husband
- ☐ Daughter (Daughter-in-law)
- ☐ Son (Son-in-law)
- ☐ Mother
- ☐ Father
- ☐ Non-relative
- ☐ Other _____

Education

- ☐ 8th Grade or less
- ☐ High School Diploma
- ☐ Some College
- ☐ Specialized Training
- ☐ Associates Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Other _____

Employment

- ☐ Retired
- ☐ Retired, but working part-time
- ☐ Part-time
- ☐ Full-time
- ☐ Unemployed
- ☐ Other _____

Race/Ethnicity (check all that apply)

- ☐ White, non-Hispanic
- ☐ Hispanic
- ☐ Asian
- ☐ Black/African-American
- ☐ Native Hawaiian/Pacific Islander
- ☐ American Indian/Native Alaskan
- ☐ Other _____

SECTION 3 - INCOME INFORMATION

If applying ONLY for the companion or student nurse program, go to page 8

In order to determine our level of cost sharing please...
Complete **Section A** If you are caring for disabled adult any age over 18,
a senior 60 plus, or Alzheimer's of any age.

In the appropriate box list all Income - Taxable and non-taxable
(Married couples must report their combined income)

Please check one: Income below, is from the past Year____ or 90 Days____

Section A. Care Recipient Income Information for adults 18 and older

Social Security	\$
Other Pensions	\$
Employment (Wages)	\$
Rental Income	\$
Interest/ Dividends	\$
Other Income	\$

Total \$ _____

Declare all income for either an individual or for both spouses if a married couple. Income includes social security, pensions, and wages from employment, interest and dividends, rental income from property, revenue from stocks.

INCOME INFORMATION

In order to determine our level of cost sharing please...

Complete Section B If you are caring for a child under the age of 18

Please check one: Household Income is from the past Year____ or 90 Days____

Section B: Care Recipient Income Information for those Under 18 years old

Federally Adjusted Gross Income (As reported annually to the IRS)	\$
Social Security, SSI, SSDI (if not reported on tax return)	\$
Other Income (If not reported on tax return)	\$

Total \$_____

Section C - Medical Expenses

Please refer to the **Medical Expenses** portion of the **Application Instructions** for details on eligible medical expenses.

No matter which of the above Income Information sections you filled out, please include information about your medical expenses, if applicable. By submitting your Medical expenses, we may be able to reduce your cost share.

Medical Expenses - Please enter the amount medical expenses paid over the past (choose one)

Year \$_____ OR 90 Days_____

**YOUR APPLICATION IS COMPLETE IF YOU HAVE INCLUDED THE
FOLLOWING:**

- ✓ **INCOME VERIFICATION**
(EXCEPT COMPANION OR NURSING STUDENT PROGRAM)
- ✓ **PROOF OF PRIMARY CAREGIVER'S ADDRESS**
- ✓ **PROOF OF CARE RECIPIENT'S AGE**
- ✓ **MEDICAL EXPENSE VERIFICATION (IF ANY)**
(EXCEPT COMPANION OR NURSING STUDENT PROGRAM)

Please send completed applications to:

CareBreaks Program
Catholic Social Services of RI
One Cathedral Square
Providence, RI 02903-3695

I certify, under penalty of perjury, that the information provide in this application is true and accurate.

Signature of Caregiver: _____ Date: _____

Signature of person completing this form if different from caregiver Date: _____

Applicants and CareBreaks recipients may be assured of the confidentiality of all respite care information. Records are kept in accordance with federal and state laws and regulations. No individual or identifying information is disclosed. Information is used only to arrange for and monitor services provided and to provide non-identifying statistics to regarding the program. Any further disclosures would require informed specific written consent from the care recipient/ caregiver.

Rev 1/20/2023