BALTIMORE CITY HEALTH DEPARTMENT

Dear Caregiver,

Thank you for contacting Baltimore City Health Department Division of Aging & CARE Services, National Caregivers Support Program for assistance with your caregiving responsibilities for your loved ones.

The Office of Aging & CARE Services is the primary program in the city responsible for advocating for and delivering services to older adults, their families, and caregivers in the City of Baltimore.

Enclosed you will find the forms needed to process your request for caregiver assistance. Please complete all forms and return them to our office as soon as possible. Please note that all applications are based on a first come, first served basis and the availability of funds.

The information contained in this application packet is legally privileged and confidential information intended for the use of this application only.

If you have any questions regarding this request or have a need for assistance with other services, please feel free to contact us at (410) 396-1337

If you need assistance with your grant application, please contact Jazmine Adams or Jose Jimenez at (410) 396-1337.

Sincerely,

Jose Jimenez
Program Administrator

Division of Aging and CARE Services
National Family Caregiver Support Program
417 East Fayette Street, 6th Fl Baltimore, MD 21202
Tel: 410-396-1337 Email: jazmine.adams@baltimorecity.gov

Family Caregiver's Grant Requirements

The National Family Caregiver Support Program (NFCSP) provides non-emergency and non-expedited financial assistance to caregivers to pay for respite or supplemental services. Monies may be paid directly to the caregiver, the care recipient or outside agency for respite or in-home services. The funds can be used to hire providers for respite services or to reimburse you for out-of-pocket expenses related to your role as a caregiver. Currently assistance is limited to **$300 per person annually (from date of processing). This assistance is subjected to availability of funds.**

Caregivers Grant Requirements:

Caregivers who are providing care to someone age 60 or older. The care recipient must require assistance with at least two activities of daily living (ADLs). A medical doctor or medical practitioner must verify the care recipient's condition and indicate what ADLs the care recipient needs assistance with by completing the Medical Status Verification Form. The caregiver must be at least 18 years old, and the care recipient must be 60 or older. The caregiver and the care recipient do not have to be blood relatives.

Grandparent or relative caregivers. Grandparents or relative caregivers who are providing care to children that are 18 years old and younger, must be at least 55 years of age or older to take advantage of the NFCSP grant opportunity. Caregivers of children 18 years of age or younger do not have to provide a completed medical verification form.

Caregivers providing care to a disabled person. Caregivers must be at least 55 years of age providing care to a disabled individual age 18 - 59. A medical verification form is required and must be completed by a medical doctor or medical practitioner, indicating the care recipients' condition and ADLs requiring assistance.

Geographic requirements:

- The care recipient must be a Baltimore City resident
- It is not required that the caregiver and the care recipient live in the same household. The geographic distance between the caregiver and the care recipient cannot exceed a 25-mile radius. If the caregiver and the care recipient do not live in the same household, a notarized letter must be provided stating the name of the primary caregiver.

How to apply: Call NFCSP at 410-396-1337 to obtain your application package or you may download one online at https://health.baltimorecity.gov/family-caregivers-program. Complete the Family Caregiver Grant Request and submit copies of receipts, invoices, or bills to accompany your reason for request. The care recipient's primary care physician must complete the Medical Status Verification Form.

The payee must complete a W-9 form before the request can be processed and the payment disbursed. **A copy of a Maryland State ID or a picture ID that verifies your age and a copy of your unaltered social security card must accompany all other requested paperwork, for both the caregiver and the care recipient**. ***Processing time may take 90 -180+ days.***

Please forward all information to:

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FAMILY CAREGIVERS PROGRAM APPLICATION

Caregiver Information

Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Sex: ☐ M ☐ F ☐ Other Date of Birth: _____ Social Security #: __ __ __ - __ __ - __ __ __ __

What is the Caregiver's Relationship to the person being cared for? _____

Reason for Request: (Be Specific) _____

Caregivers Income: ☐ Above $ 1,073/month ☐ At or Below $ 1,073/month

Are you a paid caregiver? Yes ☐ No ☐

Caregivers Race (select all that apply):
☐ Black/African American ☐ Asian/Asian American ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ White

Caregiver Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Information of Person Receiving Care

Name: _____ Phone: _____

Address: _____ DOB: _____

Social Security #: _____

Payee Information (person check will be mailed to)

Payee's Name: _____

Payee's Address: _____

Payee's Contact #: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application will result in application denial.

Signature: _____ Date: _____

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FAMILY CAREGIVERS PROGRAM APPLICATION

MEDICAL STATUS VERIFICATION FORM TO BE COMPLETED BY A LICENSED PHYSICIAN

Patient Name: _____ Phone: _____

Address: _____ DOB: _____

_____
City State Zip code

STATEMENT OF MEDICAL CONDITION

Please state the specific diagnosis of illness/injury of the above-named individual.

_____
_____
_____
_____
_____
_____

ACTIVITIES OF DAILY LIVING (ADL'S) ASSISTANCE: (REQUIRED)

Please describe what type of assistance the above-named individual requires.

_____
_____
_____
_____
_____

PHYSICIANS INFORMATION:

Please provide a handwritten signature when completing this form

_____ _____
Name of Licensed Physician (Printed) Signature of Licensed Physician

_____ _____
Phone Number Mailing Address (Please include city state and zip code)

_____ _____
Physician License Number Date Completed

If you have any questions regarding this request,
please contact M. Jazmine Adams at 410-396-1337.

Receipt, Invoice, Bill Log

Please list the receipts, invoices, and bills for what you have purchased or professional estimates for what you plan to purchase. Receipts for food are not acceptable unless it is for nutritional supplements (ex: Boost, Ensure, etc.). Provide a brief description of what each receipt, invoice, or bill is covering.

Receipt/Invoice/Bill Description	**Receipt/Invoice/Bill Amount**

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Family Caregivers Training Class Application

Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Sex: ☐ M ☐ F ☐ Other Date of Birth: _____ Social Security #: __ __ __ - __ __ - __ __ __ __

What is the Caregiver's Relationship to the person being cared for? _____

Reason for Request: (Be Specific) _____

Caregivers Income: ☐ Above $ 1,073/month ☐ At or Below $ 1,073/month

Are you a paid caregiver? Yes ☐ No ☐

Caregivers Race (select all that apply):
☐ Black/African American ☐ Asian/Asian American ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ White

Caregiver Ethnicity: ☐ Hispanic ☐ Non-Hispanic

The Family Caregiver Training Class is offered monthly. The training class is taught by a health promotions educator. Each class operates two hours a day, once a week, for a total of six weeks. On average, participation in the training class is 10-12 participants per class.

The goal of the training is to enhance and or develop caregiving skills by providing caregivers with information on a variety of topics such as hospice care, respite care, stress reduction, how to hire a private caregiver, how to communicate effectively, and much more.

In addition, the class teaches caregivers about nutrition, fall prevention, infection control, medication management, fire safety, elder abuse, and neglect. The training classes are offered free of charge to any city caregiver. All materials for the classes are covered by the program. There is no cost to attend, but due to limited space, registration is required. **Please mail or email your completed application to the address or email at the top of this application.**

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THE FOLLOWING ITEMS MUST BE SENT WITH THE COMPLETED APPLICATION:

_____ **W-9 form**. The W-9 form is to be completed by the payee listed on the application

_____ **Receipts/invoices/bills and completed log**. Please send in receipts or bills for what you have purchased or professional estimates for what you plan to purchase. Receipts for food are not acceptable unless it is for nutritional supplements. Example: Boost, Ensure, etc. A receipt/invoice/bill log must also be completed describing and listing the amount of each receipt, invoice, or bill submitted.

_____ **Medical status verification form** completed by a medical doctor (ADLs must be listed)

_____ **A copy of a photo identification card and the social security card** for both the caregiver and the care recipient.

PLEASE DO NOT FAX APPLICATION PACKET OR REQUIRED DOCUMENTS.
FAXED APPLICATIONS WILL NOT BE ACCEPTED.

PLEASE MAIL APPLICATION TO THE CAREGIVER PROGRAM
AT THE ABOVE ADDRESS

If you need additional information, please contact M. Jazmine Adams at 410-396-1337

Jose Jimenez
Program Administrator
National Family Caregiver Support Program

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EXAMPLES OF ACCEPTABLE REIMBURSEMENTS OR REQUESTS

Medical cost

- Prescription/Over the Counter Medication
- Doctor/Hospital bills
- Medical supplies (diapers, gloves, syringes, etc.)

Nutritional Supplement

- Glucerna
- Ensure or Boost
- Supligen

Household Repairs

Household Bills (please note we will not provide financial assistance if you have a turn off notice or if the amount due is 2-3x's greater than the grant amount)

Clothing for care recipient or caregiver

Bedding

- Mattresses
- Bed Frame
- Mattress Cover

Household Appliances

- Washer
- Dryer
- Stove
- Refrigerator
- Microwave
- Television

Housing Cost

- Rent
- Mortgage

School Supplies

Cleaning Supplies

Respite

- Adult/child day care cost
- Summer camp fees
- After school programs
- Outside provider reimbursement

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*