BALTIMORE CITY HEALTH DEPARTMENT

Dear Caregiver,

Thank you for contacting Baltimore City Health Department Division of Aging and Community Support, **National Family Caregiver Support Program** for assistance with your caregiving responsibilities for your loved ones.

The Division of Aging and Community Support is the primary program 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 review the packet, carefully 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; it is intended for the use of this application only.

If you need assistance with your grant application or other services, please contact me at (410) 396-1337 or 443-615-6233; email: jazmine.adams@baltimorecity.gov.

Sincerely,

Jazmine Adams

Jazmine Adams
Program Assistant

Division of Aging and Division and Community Support
Baltimore City Health Department
National Family Caregiver Support Program
417 East Fayette Street, 6th Fl Baltimore, MD 21202
Tel: 410-396-1337

Family Caregiver 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. Grant funds 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 for out-of-pocket expenses related to your role as a caregiver. **This assistance is subject to availability of funds.**

Caregiver Grant Requirements:

All caregivers must complete a caregiver's assessment with the program social worker to screen for additional resources and potential problem areas.

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 up to 90 days.***

Please forward all information to:

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FAMILY CAREGIVER PROGRAM APPLICATION

Date Received: _____

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):
☐ African American/Black ☐ Asian/Asian American
☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ White

Caregiver Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Information of Person Receiving Care

Name: _____ Phone: _____

Address: _____ DOB: _____

_____

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 CAREGIVE 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.

_____
_____
_____
_____
_____

PHYSICIAN'S 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 questions regarding this request, please contact Jazmine Adams at 410-396-1337; email: jazmine.adams@baltimorecity.gov

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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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 FAMILY CAREGIVER PROGRAM
AT THE ABOVE ADDRESS

If you need additional information, please contact M. Jazmine Adams at 410-396-1337 at the National Family Caregiver Support Program

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EXAMPLES OF ACCEPTABLE REIMBURSEMENTS OR REQUESTS

Medical

- Prescription/Over the Counter Medication
- Doctor/Hospital bills
- Medical supplies (gloves, syringes, incontinence products, 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