Kerr-Tar Area Agency on Aging
Your Anchor for Aging

Caregiver Respite Voucher Program

Eligibility Application

Caregiver Information

Full Name: _____ Age: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

County of Residence: ☐ Franklin ☐ Granville ☐ Person ☐ Vance ☐ Warren

Relationship to Care Recipient: _____

Care Recipient Information

Full Name: _____ Age:: _____
Last *First* *M.I.*

County of Residence: ☐ Franklin ☐ Granville ☐ Person ☐ Vance ☐ Warren

Number of caregivers involved in care: _____

Number of hours caregivers provide in a week: _____

Describe caregiving situation: _____

_____

_____

_____

_____

Additional Information

How did you hear about our services? *(Select all that apply)* ☐ Website ☐ Facebook ☐ Word of Mouth

☐ Billboard ☐ TV/Radio ☐ Other (please list): _____

Does care recipient have Medicaid? ☐ Yes ☐ No

Does care recipient have memory loss or confusion? ☐ Yes ☐ No

Are you currently receiving financial assistance for caregiving from other sources? ☐ No ☐ Yes (please describe) _____

_____

Which activities of daily living can care recipient perform? *(Select all that apply)*

- ☐ Eating
- ☐ Bathing
- ☐ Toileting
- ☐ Dressing
- ☐ Transferring (moving from place to place)
- ☐ Ambulating (moving around without an assistive device)
- ☐ None of the above

Which instrumental activities of daily living can care recipient perform? *(Select all that apply)*

- ☐ Home Management
- ☐ Medication Management
- ☐ Transportation
- ☐ Money Management
- ☐ Shopping
- ☐ Meal Preparation
- ☐ None of the above

Is there additional information you'd like us to know? _____

_____

_____

_____

_____

_____

Please submit form to:

Kerr-Tar Council of Governments
ATTN: Harvey Holmes, Family Caregiver Specialist
1724 Graham Avenue
PO Box 709
Henderson, NC 27536
hholmes@kerrtarcog.org