Woodward
RESPITE CARE FUND

Send application to:
Woodward Respite Care Fund
P.O. Box 460831
Glendale, CO 80246-0831
303-446-0079

REFERRAL SOURCE: Name_____

Relationship / Agency_____**Phone**_____

Date of Application _____

May we contact the above referring person for more information if needed? _____

APPLICANT / CAREGIVER INFORMATION

Caregiver's Name_____ Age_____

Address_____ City_____ Zip_____

Phone (home) _____ (cell)_____

Email address: _____

Marital Status_____ Number of children at home _____ Ages_____

Caregiver's relationship to Care Recipient _____

CARE RECIPIENT INFORMATION (about the person who is receiving care)

Recipient's Name _____ Age_____

Address_____ City _____ Zip _____

Description of illness or impairments _____

_____

_____

Length of time he/she has required care _____

Information for care recipient (not Caregiver)

* What is **care recipient's** total monthly income? _____

* If care recipient is married, are the couple's assets above or below $120,000? _____
  This includes checking accounts, savings, investments, etc., but not value of the house or car.

* Amount of rent payment $_____ Amount of mortgage payment $_____

* **NOTE: The above financial information does not affect eligibility for these funds, but helps determine if there are other resources which might be available.**

GENERAL INFORMATION

How many hours do you spend caregiving in a day or week?_____

Are you currently receiving any help with caregiving? Yes_____ No_____

If yes, from whom: Family members _____

Agency(ies) _____

How often do you receive help? _____

Have you tried to obtain assistance from other sources? Yes_____ No_____

From whom _____

Are you aware of the following programs: Home & Community Based Services Yes ____ No_____
Innovage Program (Total Long-term Care) Yes ____ No_____

Has the care recipient ever applied for any of the above programs? If yes, when?_____

_____

Do you need information on respite care providers or programs? Yes _____ No_____

How has the lack of help with caregiving or no respite care affected you the most? _____

_____

_____

ASSISTANCE REQUESTED Amount of request _____

Give a brief description of **how and when** you plan to use these funds for you to take a break from your caregiving responsibilities.

_____

_____

_____

_____

USE OF FUNDS: YOU MUST BEGIN TO USE THE FUNDS AWARDED WITHIN 3 MONTHS

FOR OFFICE USE ONLY

WRCF board member receiving application _____
Date Received _____ Committee Review Date _____
Approved_____ Amount _____ Check No. _____
Check payable to: _____
Comments: _____