alzheimer's association®

Michigan Chapter
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RESPITE CARE ASSISTANCE PROGRAM APPLICATION

Today's Date: _____

Name of Caregiver: _____ Phone Number: _____

Caregiver's Relationship to Person Living with Dementia: _____

The following questions apply to the person living with dementia:

Name: _____ Date of Birth:_____

Address: _____ City: _____ State: ____ Zip Code: _____

Diagnosis: _____ Date of Diagnosis: _____

Veteran? (circle one): Yes or No

Gender Identity (check one):

- ❏ Female
- ❏ Male
- ❏ Transgender Male
- ❏ Transgender Female
- ❏ Not listed

Does the person living with dementia identify as (check one)?:

- ❏ Lesbian or Gay
- ❏ Bisexual
- ❏ Straight or Heterosexual
- ❏ Not sure
- ❏ Not listed

Race/Ethnicity (check one):

- ❏ American Indian/Alaskan Native
- ❏ Asian
- ❏ Black/African American
- ❏ Hispanic/Latino
- ❏ Native Hawaiian/Other Pacific Islander
- ❏ White/Caucasian
- ❏ Declined to Answer
- ❏ Other: _____

Please initial the statements below to indicate your agreement and understanding of the following:

_____ I am a caregiver of a person living with dementia.

_____ I understand that it can take up to 60 days for reimbursement once receipts have been submitted to the Alzheimer's Association Michigan Chapter.

❏ **Check the box to indicate:** *I have read and understand the Respite Care Assistance Program information and verify that the above information is true and correct to the best of my knowledge.*