



Title III-E Family Caregiver Program Application for Services



- Adult Day Care
 Emergency Response
 Homemaker
 Medication Mgmt
 Grandparent/Relative Caregiver
 Material Aid
 Respite

Date: _____

CAREGIVER INFORMATION

Caregiver's Name: _____

Address: _____ City _____ State: _____ Zip: _____

Phone: _____ Providing Care For: _____

REFERRAL SOURCE

Name: _____ Agency: _____

Address: _____ Phone: _____

SERVICE REQUEST

Describe caregiver's needs and how the funds will be used.

Total Cost: \$ _____ Support Requested from Aging Resources: \$ _____

Check should be made out to: _____

Does caregiver or care recipient have other unmet needs? Yes No

If yes, please describe: _____

METHOD OF PURCHASE AND PAYMENT

_____ Send check to: _____

_____ Hold for invoice from: _____

_____ Other: _____

Mail to: Aging Resources of Central Iowa – Attn: Kay Vanags
 5835 Grand Avenue, Suite 106 – Des Moines, IA 50312-1437
 Phone: 515-255-6142, ext. 311 Fax: 515-255-9442

THE APPROVAL OF SERVICES RELATED TO THIS APPLICATION IS SUBJECT TO THE AVAILABILITY OF FUNDS AND MAY BE DISCONTINUED IF NECESSARY

FOR AGING RESOURCES' USE ONLY

Caregiver Form

Approval: _____ Date: _____

Explanation for check stub: _____