

THE VIRGINIA CAREGIVERS GRANT PROGRAM

ELIGIBILITY REQUIREMENTS

THE CAREGIVER MUST:

1. Provide unreimbursed care for a relative who has a mental or physical impairment;
2. Have an annual Virginia adjusted gross income of not more than \$50,000;
3. Reside in the Commonwealth of Virginia; and
4. Provide care to the relative for more than half the calendar year.

Relevant documentation may be requested to verify eligibility.

THE RELATIVE RECEIVING CARE MUST:

1. Require assistance with two or more activities of daily living (ADLs);
2. Require assistance during more than half the calendar year;
3. Not be receiving Medicaid-reimbursed long-term care services, except on a periodic or temporary basis; and
4. Reside in the Commonwealth of Virginia.

➤ **A licensed physician must certify that these criteria are met.**

FILING DATES

- The General Assembly did not fund this program for 2002 and 2003.
- Applications will be accepted from **February 1, 2005** through **May 1, 2005**.
- Applications will not be returned to you for additions or corrections.
- If you have not yet filed your 2004 income tax return, please DO NOT submit this application until a copy of your tax return is available.
- There is no appeal process, per Virginia statute.

For additional information, please call the Virginia Department of Social Services, Caregivers Grant Program toll-free number at **1-877-648-2817**.

HOW TO APPLY FOR A VIRGINIA CAREGIVERS GRANT

1. Read the **ELIGIBILITY REQUIREMENTS** to determine if you qualify.
2. Be certain that both the caregiver and the relative meet **ALL** the criteria.
3. Fill in the blanks in Sections I, II, and IV on the application. Answer all the questions and check all the appropriate boxes. **Do not leave any blanks.** If you do not submit the required information, or if the application is incomplete, we will be unable to approve your application.
4. Attach a copy of your Virginia 2004 tax return, including a copy of your W-2 form.
 - a. If you have not yet filed your taxes, please do not submit the application until your taxes have been filed so that you can attach a copy.
 - b. If you are not required to file a tax return, please state the reason on page 2, section IV, question 4.
5. Take the application to your physician and ask him or her to complete Section III. (You may wish to provide him or her with a copy of the **DEFINITIONS**.)
6. Sign and date the application.
7. Both your signature and the doctor's signature **MUST** be an original signature. According to Virginia statute, we cannot accept faxed or photocopied signatures.
8. Mail the signed application, with your tax return attached, to:

Virginia Caregivers Grant Program
VDSS Adult Services Program
4th Floor, 7 North Eighth Street
Richmond, VA 23219
9. The application must be **postmarked between February 1, 2005, and May 1, 2005**. Applications that are submitted prior to February 1 or after May 1 will not be considered, per Virginia statute.
10. If you have questions or need assistance completing the application, please call your local department of social service or your local area agency on aging. You may also call the Virginia Caregivers Grant 24-hour toll-free number at 1-877-648-2817. Please leave your name and telephone number, including the area code, and someone will call you back.

DEFINITIONS

MEDICAID-FUNDED LONG-TERM CARE SERVICES

Definitions for Question 3 in Section IV on the Virginia Caregivers Grant application.

The following list includes, but is not limited to, services that are defined as **Medicaid-reimbursed long-term care services**. If the relative for whom you care is receiving this type of service through Medicaid, other than on a periodic or temporary basis, the caregiver is not eligible for this grant. (The terms “**periodic**” and “**temporary**” are defined below.)

- Nursing Facility Services
- Assisted Living Facility Services
- Intermediate Care Facilities for Mentally Retarded
- Long-Stay Hospitals
- Home- and Community-Based Care Waivers (This includes the Elderly and Disabled Waiver, AIDS Waiver, Mental Retardation Waiver, Consumer-Directed Personal Attendant Services Waiver, Technology Assisted Waiver, and the Individual and Family Developmental Disabilities Support Waiver)
- Home Health Services
- Hospice Services
- Program of All-Inclusive Care for the Elderly (PACE)
- Intensive Rehabilitation Services

“**Periodic basis**” shall be defined as services received no more than twice per week. For example, a relative receiving care attends Medicaid-funded adult day care twice each week.

“**Temporary basis**” shall be defined as services received continuously for 30 days or less and occurring not more than once every three months. For example, a relative receiving care from a family caregiver requires Medicaid-funded personal care and rehabilitative services following a bone fracture that lasts for 3 weeks. In this case, the caregiver would continue to be eligible for the grant provided all other program criteria are met.

DEFINITIONS FOR USE BY PHYSICIAN

Definitions for Section III on the Virginia Caregivers Grant application.

“**Needs Help**” means whether or not the individual needs help (equipment or human assistance) to safely perform the activity.

“**Requiring assistance,**” for the purposes of the Virginia Caregivers Grant Program, means that an individual needs at least the assistance of another person (human help only) **OR** needs at least the assistance of another person and equipment or a device (mechanical help and human help) to safely complete the activity **OR** has the activity performed for him or her.

ADL Scoring Options for Bathing, Dressing, Toileting, Transferring, and Eating/Feeding. Please see policy for additional assessment information, including scoring options for the assessment of children. *The following scoring option does NOT meet the definition of requiring assistance.*

- **Mechanical Help Only** means the individual needs equipment or a device to complete the activity, but does not need assistance from another human (**d=semi-dependent**).
- **Human Help Only** means the individual needs help from another person, but does not need to use equipment in order to perform the activity. A need for human help exists when the individual is unable to complete an activity due to cognitive impairment, functional disability, physical health problems or safety. An unsafe situation exists when there currently is a negative consequence from not having help (e.g., falls, skin rash or breakdown, weight loss).
- **Supervision (Verbal Cues, Prompting)**. The individual is able to perform the activity without hands-on assistance of another person, but must have another person present to prompt and/or remind him or her to safely perform the complete activity. This code should only be used when the only way the activity gets completed is through this supervision.
- **Physical Assistance (Set-Up, Hands-On Care)**. Physical assistance means hands-on help by another human, including assistance with set-up of the activity.

Mechanical Help and Human Help means the individual needs equipment or a device and the assistance of another person to complete the activity (**D=Dependent**).

Performed by Others means another person completes the entire activity and the individual does not participate in the activity at all (**D=Dependent/Totally Dependent**).

Is Not Performed means that neither the individual nor another person performs the activity (**D=Dependent/Totally Dependent**).

ADL Scoring Options for Continence of Bowel

These three scoring options do NOT meet the criteria for requiring assistance for continence of bowel.

- **Does Not Need Help.** The individual voluntarily controls the elimination of feces (I=Independent).
- **Incontinent Less Than Weekly.** The individual has involuntary elimination of feces less than weekly (e.g., every other week) (**d=semi-dependent**).
- **Ostomy - Self-Care.** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum

(ileostomy) and he or she completely cares for the ostomy (**d=semi-dependent**).

Incontinent Weekly or More. *The individual has involuntary elimination of feces at least once a week. Individuals who use pads or adult diapers and do not dispose of them should be coded here (D=Dependent).*

Ostomy - Not Self-Care. *The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy: stoma and skin cleansing, dressing, application of appliance, irrigations, etc. (D=Dependent/Totally Dependent).*

ADL Scoring Options for Continence of Bladder

These three scoring options do NOT meet the criteria for requiring assistance with continence of bladder.

- **Does Not Need Help.** The individual voluntarily empties his or her bladder without help (I=Independent).
- **Incontinent Less Than Weekly.** The individual has involuntary emptying or loss of urine less than weekly. (**d=semi dependent**).
- **External/Indwelling Catheter or Ostomy - Self-Care.** The individual has a urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter) or a surgical procedure that establishes an external opening into the ureter(s) (ostomy). The individual completely cares for urinary devices (changing the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. Individuals who use pads or adult diapers and correctly dispose of them themselves should be coded here. (**d=semi-dependent**).

Incontinent Weekly or More. *The individual has involuntary emptying or loss of urine at least once a week. Individuals who use pads or adult diapers and do not dispose of them should be coded here (D=Dependent).*

External Device - Not Self-Care. *Individual has a urosheath or condom with a receptacle attached to collect urine. Another person cares for the individual's external device. This code should never be used with individuals who only use pads or adult diapers (D=Dependent/Totally Dependent).*

Indwelling Catheter - Not Self-Care. *Individual has a hollow cylinder passed through the urethra into the bladder. Another person cares for the individual's indwelling catheter (D=Dependent/Totally Dependent).*

Ostomy - Not Self Care. *Individual has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the individual's ostomy (D=Dependent/Totally Dependent).*

(Revised 11/7/2001)

**VIRGINIA DEPARTMENT OF SOCIAL SERVICES
2005 VIRGINIA CAREGIVERS GRANT PROGRAM
APPLICATION**

PLEASE DO NOT
WRITE IN THIS BOX.

The Virginia Caregivers Grant Program, authorized by Senate Bill 910 (1999), provides for an annual grant to caregivers who provide assistance to a relative with a mental or physical impairment. This is a yearly grant payment up to \$500, which will be paid on or before December 31, 2005, **if funds are appropriated by the General Assembly**. This application is for care that was provided to a relative in the year 2004. The grant is considered taxable income by the IRS and may be used at the caregiver's discretion. Both the caregiver and the relative receiving care must meet certain eligibility criteria, and a list of those requirements is attached to this application. **APPLICATIONS ARE ACCEPTED BETWEEN FEBRUARY 1 AND MAY 1 OF EACH YEAR FOR CARE PROVIDED IN THE PRECEDING CALENDAR YEAR.** Applications postmarked prior to February 1, 2005, and after May 1, 2005, will not be considered.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

There are four (4) sections to this application. **All questions MUST be answered for the application to be considered complete.** An incomplete application will disqualify you; applications will **NOT** be returned to you for correction. The caregiver and physician signatures **MUST BE ORIGINALS.** (Copies and/or faxed signatures will not be accepted.) If you need assistance in filling out this application, please contact your **LOCAL DEPARTMENT OF SOCIAL SERVICES** or your **LOCAL AREA AGENCY ON AGING**.

PLEASE PRINT ALL INFORMATION, EXCEPT YOUR SIGNATURE.

SECTION I: Information in this section pertains to the CAREGIVER.

Last Name:					
First Name:		Middle Initial:		Sex:	
Street Address:					
City:			State: VA	Zip Code:	
Area Code:	Telephone:		Birth Date:		
Social Security Number:					
How many months <u>in the year 2004</u> did you care for your relative?					
What is your relationship to the relative for whom you cared? Please check one of the following boxes.					
I am the:	Husband <input type="checkbox"/>	Parent <input type="checkbox"/>	Grandparent <input type="checkbox"/>	Sister <input type="checkbox"/>	Other: (Please specify)
	Wife <input type="checkbox"/>	Child <input type="checkbox"/>	Grandchild <input type="checkbox"/>	Brother <input type="checkbox"/>	

SECTION II: Information in this section pertains to the RELATIVE receiving care.

Last Name:					
First Name:		Middle Initial:		Sex:	
Street Address:					
City:			State: VA	Zip Code:	
Area Code:	Telephone:		Birth Date:		
Social Security Number:					

SECTION III: Information in this section must be provided by a PHYSICIAN.

Patient's Name:

Primary Diagnosis:

I certify that I have assessed the above-named individual and found him/her to need assistance with the following activities of daily living (ADLs) as checked below, in accordance with the relevant state regulations (see definitions attached.)

Bathing <input type="checkbox"/>	Dressing <input type="checkbox"/>	Bladder Continence <input type="checkbox"/>	Transferring <input type="checkbox"/>
Toileting <input type="checkbox"/>	Eating/Feeding <input type="checkbox"/>	Bowel Continence <input type="checkbox"/>	

Physician's **PRINTED** Name:

Physician's License #:

Physician's Telephone #:

Physician's Signature:

Date:

SECTION IV: This section provides certification about the accuracy of the application and the CAREGIVER'S SIGNATURE.**PLEASE READ STATEMENTS (1) THROUGH (7) BELOW, AND IF YOU AGREE, PUT A CHECKMARK IN THE BOX NEXT TO IT.**

- (1) I certify that I provided unreimbursed (unpaid) care to my relative for at least six (6) months in the year 2004.
- (2) I certify that both my relative and I are residents of the Commonwealth of Virginia.
- (3) I certify that the relative for whom I am caring is **NOT** receiving a Medicaid-reimbursed long-term care service, except on a periodic or temporary basis as defined on the attached page. (Please read definitions on attached page.)
- (4) I certify that my adjusted gross income for the year 2004 was less than \$50,000. (This refers to the **CAREGIVER'S** income.) To verify your income, please check box A or B below.

IF YOU HAVE NOT YET FILED YOUR 2004 INCOME TAX RETURN, PLEASE DO NOT SUBMIT THIS APPLICATION UNTIL A COPY OF YOUR TAX RETURN IS AVAILABLE. IF THE TAX INFORMATION IS NOT INCLUDED, YOUR APPLICATION WILL BE INCOMPLETE AND WILL NOT BE CONSIDERED.

- A. I have attached a copy of my Virginia Income Tax form for the year 2004. (This is the form you file with the Virginia Department of Taxation, **NOT** a W-2 form.)
- B. I did not file a Virginia tax return for the year 2004 and do not plan to do so.

If you checked box B above, please explain why you did not file a tax return by marking one of the four boxes below.

- I only receive Social Security benefits. Other: (please specify) _____
- I did not work in 2004.
- My income was too low to file. _____

- (5) I understand that the decision of the Virginia Department of Social Services (VDSS) regarding this grant is final and **not open to appeal.**
- (6) I agree to make available to VDSS, if requested, all relevant and applicable documents used to determine whether I meet the requirements for the receipt of this grant, and I agree that VDSS may use all relevant information relating to eligibility for the requested grant. I agree that the documentation submitted cannot be returned to me and remains the property of VDSS.
- (7) I understand that this application must be filled out completely and accurately, or it will not be considered. I understand that an extension of time cannot be granted, per Virginia statute.

Signature of Caregiver:

Date:

Send the completed application to
**VIRGINIA CAREGIVERS GRANT PROGRAM, VDSS Adult Services Program, 4th Floor, 7 North Eighth Street,
 Richmond, VA 23219.** If you have a question, call toll free 1-877-648-2817.

This application must be postmarked no earlier than February 1, 2005, and no later than May 1, 2005.