



Dementia/Alzheimer's Grant Application
for Respite Voucher

Section 1

Return to:
DEAP
2200 Box Elder Suite 151
Miles City, MT 59301
attn: Vicki Clear

Care Recipient Information

These questions are about the person who is to be cared for.

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

Gender: Male Female Is the care recipient a veteran? Yes No

Race: Native American or Alaska Native Asian or Asian American

Black/African American Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic or Latino # of people in household _____

About the Care Recipient – answer all that apply:

- Alzheimer's Diagnosis Traumatic Brain Injury
- Other Dementia Diagnosis (list type) _____
- Undiagnosed Dementia Seizures – type _____
- Unable to be Left Unattended
- Other comments: _____

Living Arrangement: Alone With spouse only With spouse & other relatives

With other relatives With Grandparent(s) With non-relative With parent(s)

With son or daughter With grandchild With brother or sister

My primary caregiver is my: Wife Husband Daughter Son Brother
(Check only one)

Sister Daughter/Son (in-law) Mother Father Grandchild

Other Relative Non-Relative (specify) _____

Section 2

Primary Caregiver Information

These questions are about the caregiver – the person who does the daily caregiving.

Last Name: _____ First Name: _____

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Cell phone: _____

Email: _____ Date of Birth: _____

Gender: Male Female Are you a veteran? Yes No

Race: Native American or Alaska Native Asian or Asian American

Black/African American Native Hawaiian or Pacific Islander White

Ethnicity: Hispanic or Latino

Number of hours the caregiver is responsible for care recipient in an average week: _____

Type of services I'm interested in for the care recipient:

In-home hourly care Temporary overnight care Adult Day Care

Social Outing Crisis Care Other _____

Resource(s) that would make respite possible: _____

(such as: door alarm, ID bracelet with address, etc.)

Call the Alzheimer's Association 24/7 Help Line at 800-272-3900 for more resource ideas.

I certify, under penalty of perjury, that the information provided in this application is true and accurate.

Signature of Caregiver: _____

Date: _____

*****Where did you hear about this respite voucher program:**
