



Gloucester Adult Day Care Scholarship Application

Purpose:

Bay Aging is offering scholarships to assist those with Adult Day Care needs who have limited resources. The purpose of this scholarship is to promote individuals to remain in their current living environment and to assist caregivers with respite services. This scholarship provides financial assistance to those seeking adult day health services who do not have the ability to pay or who may be uninsured.

Eligibility:

Individuals who are 18 years of age or older who have been diagnosed with Dementia, Alzheimer's, Cognitive Decline, or a Developmental Disability and are unable to perform at least two activities of daily living without substantial assistance and require supervision in order to remain safely in their home or current living environment. Applicants must reside within the Bay Aging catchment area. Bay Aging can assist with transportation.

This is a needs-based scholarship. Eligibility will be based on a point system that determines risk based on living arrangements, ADL dependencies, medical/nursing needs, cognitive impairment/behavior, income, medication needs, and mobility. Scholarships are awarded without regard to race, color, religion, sex, or age.



Gloucester Adult Day Care Scholarship Application

Participant's Name _____ Date _____

Address: _____

City/County _____ State _____ Zip Code _____

County _____

Telephone # _____

Diagnosis _____

Where does the participant currently live?

Own Home ____ With Family ____ Other ____

Caregiver Name _____

Address: _____

City/County _____ State _____ Zip Code _____

Telephone# _____

Email Address _____

Age of Caregiver _____ Relationship to the Participant _____

How long has the primary caregiver been providing care?

(Months/Years) ____ / ____

Does the primary caregiver have any additional persons providing supports?

Yes ____ No ____

If yes, how many? _____



P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

How many people currently reside in the home? _____

What are their relationships to the participant? _____

How often does the primary caregiver receive a “break”? _____

Is the participant able to be left alone, unsupervised during the day, with no one else in the home? Yes _____ No _____

Is the participant able to be left alone, unsupervised in one room while the primary caregiver is in another room? Yes _____ No _____

How many hours a day does the primary caregiver feel they are providing direct care to the participant each day? _____

Primary caregiver’s overall, general health? Good _____ Fair _____ Poor _____

Please describe any health problems of the primary caregiver below:

What is the reason for seeking Adult Day Care Services. Please check ALL that apply:

- Caregiver’s Health
- Caregiver Still Employed
- Caregiver Burnout
- Participant in Need of Meaningful Interactions
- Participant Behaviors



P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

Please list/describe participant memory deficits:

Please list/describe current behavior concerns of the participant:

Please list/describe all of the participants current health problems/concerns:

Is the participant able to ambulate independently? Yes ___ No ___

If no, please describe assistance needed:

Does the participant use (check ALL that apply):

- wheelchair walker
 gait belt rollator
 Hoyer lift Other, please list _____

If the participant utilizes a wheelchair, are they able to support their weight, pivot, offer assistance when transferring? Yes ___ No ___



P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

What ADL's does the participant require assistance with (please check ALL that apply)?

Toileting Bathing Medication
 Eating/Feeding Dressing

What types of behaviors does the participant exhibit (check ALL that apply)?

Wandering Elopement Verbally/Physically Aggressive
 Other, describe: _____

Does the participant sleep through the night? Yes No

Does the participant have any mental health diagnosis? Yes No

If yes, please list diagnosis: _____

Does the participant experience any incontinence? Bladder Bowel

Does the participant wear incontinence briefs? Yes No

If yes, please describe frequency: _____

Has the participant experienced any falls within the last 6 months? Yes No

If yes, please list # of falls: _____

Does the participant attend church, meetings or actively a part of any organizations? Yes No

Does the participant have friends or family who visit regularly? Yes No

Does the participant go out for meals or other social events on a regular basis?
Yes No



P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

Is the participant a Veteran? Yes ___ No ___

Does the participant receive any VA Benefits? Yes ___ No ___

If yes, please list: _____

Does the participant have a Medicaid Waiver? Yes ___ No ___

Does the participant have any paid caregivers? Yes ___ No ___

If yes, please list services received: _____

Is the participant currently on hospice care? Yes ___ No ___

Does the participant receive SSI? Yes ___ No ___

Does the participant receive Retirement? Yes ___ No ___

Please list all sources of income for all adults residing in the household:

Does the participant have a POA or other Legal Representative? Yes ___ No ___

Please check the category of all/total annual income for all adults residing in the household:

- | | | |
|-----------------------|-----------------------|-----------------------|
| ___ \$5,000-\$9,999 | ___ \$10,000-\$14,999 | ___ \$15,000-\$19,999 |
| ___ \$20,000-\$24,999 | ___ \$25,000-\$29,999 | ___ \$30,000-\$34,999 |
| ___ \$35,000-\$39,000 | ___ \$40,000-\$44,999 | ___ \$45,000-\$49,999 |
| ___ Over \$50,000 | | |

On a scale of 1-5, with 1 being not at all and 5 being extreme hardship, how difficult is it for you to pay for household expenses such as food, clothing, heating, gas, utilities, rent/mortgage, medical care and prescriptions? _____



P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

Please provide a summary of the needs of the participant and why they will benefit from an ADC scholarship?

I attest that the above information is accurate and correct. I understand that if considered for this scholarship, I will be asked to provide income verification.

Caregiver Signature: _____ **Date:** _____

Participant Signature: _____ **Date:** _____

Download form after filling out and either email to sblanks@bayaging.org or print and mail to PO Box 610 Urbanna VA 23175 Questions call 804-695-9008