BAY AGING
DIGNITY AT EVERY AGE
P.O. Box 610 • 5306 Old Virginia Street • Urbanna, VA 23175 • 804-758-2386 • www.bayaging.org

Gloucester Adult Day Center
Scholarship Application

Purpose:

Bay Aging is offering scholarships to assist those with Adult Day Cneter 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.

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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? _____

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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

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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 ☐

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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 ☐

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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:

- ☐ $5,0000-$9,9999
- ☐ $10,000-$14,999
- ☐ $15,000-$19,999
- ☐ $20,000-$24,9999
- ☐ $25,000-$29,999
- ☐ $30,000-$34,9999
- ☐ $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? _____

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

_____

_____

_____

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_____

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