



**Send application to:**  
Woodward Respite Care Fund  
P.O. Box 460831  
Glendale, CO 80246-0831  
303-446-0079

**Application for Funds**

REFERRAL SOURCE: Name \_\_\_\_\_

Relationship / Agency \_\_\_\_\_ Phone \_\_\_\_\_

Date of Application \_\_\_\_\_

**APPLICANT / CAREGIVER INFORMATION**

Caregiver's Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_

Email address: \_\_\_\_\_

Marital Status \_\_\_\_\_ Number of children home \_\_\_\_\_ Ages \_\_\_\_\_

Caregiver's relationship to Care Recipient \_\_\_\_\_

Do **you** have monthly out-of-pocket expenses for the **care recipient's needs** (for things such as medications, therapies, home help, etc.) \_\_\_\_\_

What are these expenses? \_\_\_\_\_

**CARE RECIPIENT INFORMATION** (about the person who is receiving care)

Recipient's Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Description of illness or impairment \_\_\_\_\_

Length of time he/she has required care \_\_\_\_\_

What is care recipient's total monthly income? \_\_\_\_\_

Are there monthly out-of-pocket **expenses** for which the **care recipient pays** which are not covered by insurance, such as medications, therapies, home help? \_\_\_\_\_

What are these expenses? \_\_\_\_\_

**GENERAL INFORMATION**

How many hours do you spend caregiving in a day or week? \_\_\_\_\_

Are you currently receiving any help with caregiving? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, from whom: Family members \_\_\_\_\_

Agency(ies) \_\_\_\_\_

How often do you receive help? \_\_\_\_\_

Have you tried to obtain assistance from other sources? Yes \_\_\_\_\_ No \_\_\_\_\_

From whom \_\_\_\_\_

Are you aware of the following programs: Home & Community Based Services Yes \_\_\_\_\_ No \_\_\_\_\_  
Total Long-term Care Yes \_\_\_\_\_ No \_\_\_\_\_

Has the care recipient ever applied for any of the above programs? If yes, when? \_\_\_\_\_

Do you need information on respite care providers or programs? Yes \_\_\_\_\_ No \_\_\_\_\_

How has the lack of help with caregiving or no respite care affected you the most? \_\_\_\_\_

**ASSISTANCE REQUESTED** Amount of request \_\_\_\_\_

Give a brief description of how you plan to use these funds for you to take a break from your caregiving responsibilities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**USE OF FUNDS - IF APPROVED, FUNDS MUST BE USED WITHIN 6 MONTHS**

**FOR OFFICE USE ONLY**

WRCF board member receiving application \_\_\_\_\_

Date Received \_\_\_\_\_ Committee Review Date \_\_\_\_\_

Approved \_\_\_\_\_ Amount \_\_\_\_\_ Check No. \_\_\_\_\_

Check payable to: \_\_\_\_\_

Comments: \_\_\_\_\_