

**NEW YORK STATE OFFICE FOR THE AGING**

2 Empire State Plaza, Albany, NY 12223-1251

Andrew M. Cuomo, Governor

An Equal Opportunity Employer

Corinda Crossdale, Director

<p><b>PROGRAM INSTRUCTION</b></p>	<p><b>Number 15-PI-03 (revised)</b></p>
	<p><b>Supersedes 15-PI-03</b> (issued March 11, 2015)</p>
	<p><b>Expiration Date</b></p>

**DATE:** January 20, 2016

**TO:** Area Agency on Aging Directors

**SUBJECT:** Balancing Incentive Program (BIP) Caregiver Support Program  
Funding Announcement and Grant Application

.....  
**ACTION REQUESTED:**

All AAAS are eligible to apply for one time funding to provide additional caregiver support services through the Balancing Incentive Program (BIP) Caregiver Support Program (Program) for the period of April 1, 2015 to June 30, 2017. Area Agencies on Aging (AAAs) must complete and submit to the New York State Office for the Aging (NYSOFA) the BIP Caregiver Support Program Application for Funding (revised) (see Attached) and BIP Caregiver Support Program Budget (revised) (see Attached).

**RESPONSE DUE DATE:** February 22, 2016

Applications must be submitted electronically to NYSOFA by February 22, 2016. Electronic applications must include the BIP Caregiver Support Program Application for Funding (revised) and BIP Caregiver Support Program Budget (revised), and a scanned copy of the **signed** cover page in order to be considered for funding. Email to [Caregiver@aging.ny.gov](mailto:Caregiver@aging.ny.gov) with a cc to [karen.iovino@aging.ny.gov](mailto:karen.iovino@aging.ny.gov).

If your county opts **not to apply** for these funds, please send notification to [Caregiver@aging.ny.gov](mailto:Caregiver@aging.ny.gov) and [karen.iovino@aging.ny.gov](mailto:karen.iovino@aging.ny.gov) no later than February 2, 2016.

## **PURPOSE:**

The purpose of this Program Instruction (PI) is to transmit guidance on grant funds available for the BIP Caregiver Support Program. This Program, based on services of the Older Americans Act (OAA) Title III-E program, provides an opportunity for AAA participation through the submission of an Application for Funding to NYSOFA. The BIP Caregiver Support Program will increase offerings and access to non-institutional long term services and supports for caregivers and their Medicaid-eligible loved ones.

## **BIP CAREGIVER SUPPORT PROGRAM:**

### **1. Administration and Monitoring:**

- AAAs will administer the BIP Caregiver Support Program using existing staff, including Caregiver Program Coordinators.
- To administer the Program, AAAs may expend up to ten (10) percent of the funds on administration.
- To implement services and programs under this grant such as counseling, support groups, etc., staffing is separate from the ten (10) percent administrative limit noted in bullet two, above.
- This program requires a Medicaid eligibility verification process. After documenting the identity of the Caregiver and Care Receiver, the AAA documents the verification of Care Receiver's Medicaid status as follows on the BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised):
  1. Information seen on the Eligibility Card (formerly MA card);
  2. AAA calls the LDSS/HRA to confirm eligibility; and
  3. AAA keeps a record/documentation of the Care Receiver Eligibility Card information and the date and person at the LDSS/HRA who confirmed MA eligibility.
- This Program will be monitored following the guidelines currently used for the OAA Title III-E program.
- The BIP Caregiver Support Program period will be April 1, 2015 – June 30, 2017.
- All final vouchers must be received by NYSOFA by August 1, 2017. No vouchers will be accepted beyond August 1, 2017.

### **2. Data Collection and Reporting:**

To ensure compliance with the BIP Caregiver Support Program, the following information must be collected and retained at the AAA for each Caregiver served using the prescribed BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised) (see Attached).

- Signed attestation that establishes relationship of Caregiver to identified

- Medicaid eligible Care Receiver;
- Medicaid ID number of Care Receiver; and
- For Supplemental and Respite Services - documentation that Care Receiver Programmatic Eligibility has been met (*see PI Section 3., Eligibility.*)

The following information must be provided to NYSOFA on a quarterly basis.

- Units of Service (*see PI Section 4., Service Category*);
- Expenditures; and
- Clients Served

Further details on reporting will be provided separately from this PI.

### 3. Eligibility

- Caregivers of the following Care Receivers are eligible to be considered for this program: dual eligible clients (i.e., those clients currently served by AAAs who have been identified as receiving health insurance through Medicaid/Medicare, **and** are receiving one or more long term service and/or support through the AAA, or clients who are waiting for such services); Caregivers of individuals receiving Medicaid Managed Long Term Services and Supports; and Caregivers of individuals verified as Medicaid eligible.
- **Care Receiver Programmatic Eligibility Criteria:**
  - The Care Receiver must have a Medicaid number verified by the AAA on the BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised).
- **Caregiver eligibility for Respite and Supplemental Services:**
  - (1) The Care Receiver, due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual; or
  - (2) The Care Receiver is unable to perform at least two (2) Activities of Daily Living (ADLs) (eating, dressing, bathing, toileting, mobility, personal hygiene, and transferring from bed or chair) without substantial human assistance, including verbal reminding, physical cueing, or supervision; or
  - (3) The Care Receiver requires substantial human assistance to accomplish two (2) Instrumental Activities of Daily Living (IADLs) (housekeeping, shopping, preparing meals, managing money, laundry, using transportation, telephoning and taking medication.)

Note: The Caregiver eligibility for Respite and Supplemental Services criteria are based on the OAA Title III-E Program, with the addition of IADLs per Expanded In-home Services for the Elderly (EISEP) standards.

- Caregiver Eligibility must be documented using the BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised) (see Attached).
4. Service Category (per Standard Definitions of Services):
- Counseling, Support Groups, Training (e.g., Powerful Tools, an evidence-based, six-week training program for Caregivers to develop self-care tools <http://www.powerfultoolsforcaregivers.org>).
  - Case Management

**The following services may be provided only after maximizing all available Medicaid benefits:**

- Respite, which may include:
  - Adult Day Services (social or medical model)
  - In-home contact and support (e.g., friendly visiting)
  - Personal Care Level 1 and/or 2
  - Consumer-directed Personal Assistance Services (Levels 1 and/or 2, same as EISEP Consumer Directed services model)
  - Overnight respite in social or medical day program/center (institutional respite is not allowed).
- Supplemental Services, which may include:
  - Home Delivered Meals
  - Congregate Meals
  - Nutrition Counseling and Education
  - Assisted Transportation/Escort
  - Transportation
  - Other--for those services not separately defined (e.g., home modifications), expenditures must be reasonable and documented.

Note: PERS is **not** an eligible service.

**Attachments:**

- BIP Caregiver Support Program Application for Funding (revised)
- BIP Caregiver Support Program Budget (revised)
- BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised)
- BIP Caregiver Support Program Allocation Schedule

**PROGRAMS AFFECTED:**

- |                                      |  |  |                                 |                                 |
|--------------------------------------|--|--|---------------------------------|---------------------------------|
| <input type="checkbox"/> Title III-B | <input type="checkbox"/> Title III-C-1 | <input type="checkbox"/> Title III-C-2 |                                 |                                 |
| <input type="checkbox"/> Title III-D | <input type="checkbox"/> Title III-E   | <input type="checkbox"/> CSE           | <input type="checkbox"/> SNAP   | <input type="checkbox"/> Energy |
| <input type="checkbox"/> EISEP       | <input type="checkbox"/> NSIP          | <input type="checkbox"/> Title V       | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP  |

x Other: BIP  
Caregiver Support  
Program

**CONTACT PERSON:** Karen Iovino

**TELEPHONE:** (518) 474-0099

**New York State Office for the Aging  
Balancing Incentive Program (BIP) Caregiver Support Program  
Allocation Plan**

**Allocation Schedule @ 20,000 Minimum Base**

<u>Area Agency</u>	<u>Population</u>	<u>Allocation</u>
ALBANY	60,195	\$51,049
ALLEGANY	10,426	20,000
BROOME	44,485	37,726
CATTARAUGUS	15,918	20,000
CAYUGA	17,062	20,000
CHAUTAUQUA	30,565	25,921
CHEMUNG	19,339	20,000
CHENANGO	11,797	20,000
CLINTON	15,552	20,000
COLUMBIA	16,219	20,000
CORTLAND	9,246	20,000
DELAWARE	12,947	20,000
DUTCHESS	57,062	48,392
ERIE	197,246	167,278
ESSEX	9,835	20,000
FRANKLIN	9,358	20,000
FULTON	12,488	20,000
GENESEE	12,908	20,000
GREENE	11,971	20,000
HAMILTON	1,568	20,000
HERKIMER	15,022	20,000
JEFFERSON	18,408	20,000
LEWIS	5,557	20,000
LIVINGSTON	12,840	20,000
MADISON	14,426	20,000
MONROE	145,640	123,513
MONTGOMERY	11,394	20,000
NASSAU	283,610	240,521
NIAGARA	47,641	40,402
ONEIDA	52,282	44,339
ONONDAGA	91,166	77,315
ONTARIO	23,803	20,186
ORANGE	59,933	50,828
ORLEANS	8,698	20,000
OSWEGO	22,299	20,000
OTSEGO	14,323	20,000
PUTNAM	18,429	20,000
RENSSELAER	31,155	26,421
ROCKLAND	59,153	50,166
ST. LAWRENCE	21,907	20,000
SARATOGA	43,943	37,267
SCHENECTADY	31,758	26,933
SCHOHARIE	7,560	20,000
SCHUYLER	4,386	20,000
SENECA	7,717	20,000
STEUBEN	21,915	20,000
SUFFOLK	285,071	241,760
SULLIVAN	16,666	20,000
TIOGA	11,221	20,000
TOMPKINS	16,042	20,000
ULSTER	39,054	33,121
WARREN	15,913	20,000
WASHINGTON	13,633	20,000
WAYNE	19,328	20,000
WESTCHESTER	192,309	163,091
WYOMING	8,211	20,000
YATES	5,913	20,000
NEW YORK CITY	1,407,635	1,193,771
SENECA INDIAN RES.	1,608	20,000
ST. REGIS MOHAWK	447	20,000
<b>Total</b>	<b>3,684,203</b>	<b>\$3,500,000</b>

**New York State Office for the Aging**  
**Balancing Incentive Program (BIP) Caregiver Support Program**  
**Application for Funding**

Grant Period: April 1, 2015 – June 30, 2017

Area Agency on Aging: \_\_\_\_\_

Director: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

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

Contact person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

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

The Area Agency on Aging agrees to comply with all terms and conditions of this Grant Agreement, as set forth in this funding application, including the Standard Assurances for the BIP Caregiver Support Program Grant.

\_\_\_\_\_  
Name of person authorized to enter into agreement  
with the New York State Office for the Aging

Title: \_\_\_\_\_

\_\_\_\_\_  
Signature of person authorized to enter into agreement  
with the New York State Office for the Aging

Date: \_\_\_\_\_

**Standard Assurances  
BIP Caregiver Support Program Grant**

The Area Agency on Aging (AAA), as grantee, understands that this funding application outlines the terms of the Grant Agreement, as approved by the New York State Office for the Aging (NYSOFA). The AAA agrees to comply with all New York State and Federal laws and regulations that are applicable to this Grant Agreement and to comply with the following requirements that govern the AAAs use of grant funds for the activities funded under this grant:

1. The Area Agency on Aging agrees to comply with all applicable State and Federal laws, regulations, requirements and conditions included in its Annual Implementation Plan and this application for funding as approved, including but not limited to, the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) and Article 15 of the New York State Executive Law (Human Rights Law).
2. The AAA agrees that the Application and Budget included in this Funding Application as approved by NYSOFA, are part of this Grant Agreement and shall not be modified without the written consent of NYSOFA. The AAA shall furnish NYSOFA required supportive documentation for any such changes by utilizing the forms and procedures included in 05-PI-09, Modification Procedures for Grant Applications, dated June 15, 2005.
3. The AAA agrees to fulfill the reporting requirements of NYSOFA under this Grant Agreement. This includes submission of required quarterly and final reports using the form and schedule prescribed by NYSOFA.
4. The AAA agrees that the Grant Agreement may not be assigned by the AAA or its right, title or interest therein assigned, transferred, conveyed, or disposed of without the previous consent, in writing, of NYSOFA.
5. The AAA must submit appropriate state vouchers for reimbursement of expenses incurred in the conduct of this Grant Agreement on a monthly or quarterly basis in such form as required by NYSOFA. The final voucher for expenses incurred in the conduct of this Grant Agreement must be submitted to the Office as soon as possible but no later than sixty (60) days after the ending date of the grant period.
6. The AAA agrees that state vouchers submitted for reimbursement of expenses incurred in the conduct of this Grant Agreement will not include any expenses which have been, or will be, reimbursed from other sources (e.g., other state or federal funds).
7. The AAA agrees to use the funds obtained under this Grant Agreement only for items of expense that are applicable to the activities noted in this application. Allowable items of

expense shall be reasonable, allocable and necessary to carry out the activities described in the Grant Agreement.

8. The AAA will administer the BIP Caregiver Support Program, using existing staff including Caregiver Coordinators and expend no more than ten (10) percent of the funds on administration. Program staffing is separate from this limit (e.g., direct service or contract for counseling, support groups, training, etc.).
9. The AAA will collect, track, monitor, and/or report as prescribed by 15-PI-03 (revised) using the BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form to ensure compliance with the BIP Caregiver Support Program.
10. The AAA will establish a process to verify that the Care Receiver of Caregivers served through this program have a Medicaid identification (ID) number, and must include the Medicaid ID number on a completed Caregiver/Care Receiver Required Information Form. This Form must be retained by the AAA for monitoring purposes.
11. NYSOFA may terminate the BIP Caregiver Support Program Grant Agreement immediately, upon written notice of termination to the Grantee, if the Grantee fails to comply with the terms and conditions of this Grant Agreement and/or with any laws, rules, regulations, policies, or procedures affecting this Grant Agreement.

### BIP Caregiver Support Program Application

**Instructions:** For any and all services you plan to provide through this Program:

- Check the box to indicate whether the service will be directly provided, subcontracted, or both.
- For each service category that will be provided, include the estimated number of units for that service category.
- Describe all activities that may be included for the service in the Comment/Brief Description column.
- In the box provided below this chart, provide an estimate of the number of Caregivers you plan to serve.

Direct	Subcontract	Service Category	Estimated Number of Units	Comment/Brief Description
		Counseling, Support Groups, Training (e.g., Powerful Tools)		
		Case Management		
		<b>Respite</b>		
		Adult Day Services (social and/or medical model)		
		In-home contact and support (e.g., friendly visiting)		
		Personal Care Level 1 and 2		
		Consumer-directed Personal Assistance Services (Levels 1 and 2, same as EISEP Consumer Directed services model)		
		Overnight respite in social and/or medical adult day services program/center (institutional respite is <b>not</b> allowed).		
		<b>Supplemental Services</b>		
		Home Delivered Meals		
		Congregate Meals		
		Nutrition Counseling and Education		
		Assisted Trans./Escort		
		Transportation		
		Other – for those services not separately defined (e.g., home modifications). Expenditures must be reasonable and documented. PERS is <b>not</b> allowed.		

Provide an estimate of the number of Caregivers you plan to serve:	<b>N =</b> _____
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**Balancing Incentive Program (BIP) Caregiver Support Program  
2015-2017  
SUMMARY BUDGET**

AAA: \_\_\_\_\_ **Allocation Amount**

Program Period: April 1, 2015 - June 30, 2017

<b>Budget Category</b>		<b>Budget Amount</b>
1	Personnel	
2	Fringe Benefits	
3	Equipment	
4	Travel	
5	Maintenance and Operations	
6	Other Expenses	
7	Contracts and/or Consultants	
8	<b>Total Budget (Sum of Lines 1-7)</b>	
9	<b>State Funds Requested</b>	
10	<b>Local Funds</b>	

Notes The Total Budget amount (Line 8) must equal the Total Budget amount (Line 8) on the last page.

Enter the amount of funds to be used for administration: \_\_\_\_\_  
Administrative costs may not exceed 10% of the total budget.

**Balancing Incentive Program (BIP) Caregiver Support Program 2015-2017  
Supporting Budget Schedule**

AAA: \_\_\_\_\_

1. Personnel - AAA salaries are listed here.										
Complete for Each Position (N)ame, (T)ite, (L)ocation	Annual Salary or Hourly Rate*	Hours worked on program per week	Total Hours worked per week	% of Time	Chargeable to Program		Narrative justification: For each position, provide a brief summary of duties related to each program.			
					Months Worked on Program (Full Term is 27 months)	Amount				
1 N T L										
2 N T L										
3 N T L										
4 N T L										
5 N T L										
6 N T L										
7 N T L										
8 N T L										
9 N T L										
10 N T L										
11 N T L										
<b>TOTAL Program Personnel:</b>										

\*Note: If employee is paid a salary, then list the annual salary. If employee is not on salary, then list the hourly rate. When reporting the rate of pay on vouchering forms, the format (i.e., salary or hourly rate) must match this budget (although the actual salary or the hourly rate paid may be different than budgeted).

**2. Fringe Benefits - Fringe Benefits should be directly proportional to that portion of personnel costs that are program related. Provide a clear justification if the expenses are not proportionally allocated.**

<b>Fringe Benefit Rate %:</b>	<b>TOTAL Fringe:</b>
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# Balancing Incentive Program (BIP) Caregiver Support Program 2015-2017 Supporting Budget Schedule

AAA: \_\_\_\_\_

<b>6. Other Expenses: List specific item and cost.</b>			
Promotional materials in the form of informational brochures and the like and "Giveaways" are not allowable expenses under this funding.			
Itemize all Information Technology (IT) costs and provide a justification. This includes such things as the number of licensing user fees, for whom and associated cost, licensing agreement amount, maintenance cost, reporting upgrading fees and/or, program website costs. An itemized bill from the vendor will be accepted as documentation, as long as it breaks out the costs appropriately.			
			<b>Program Expenses</b>
<b>Public Education:</b>			
<b>Information Technology:</b>			
<b>Other (Specify):</b>			
<b>TOTAL Other Expenses:</b>			
<b>7. Contracts/Consultants:</b> List each contractor or consultant and amount below. A copy of each contract or consultant agreement must be submitted to NYSOFA before reimbursement will be made. Complete and submit a Contractor Budget for each contractor that will receive 25% or more of your grant amount. For Consultants, please list unit rate (e.g., \$25 per hour) and Number of Units in the columns provided. (Note: If you hire a translator, language and/or sign interpreter, include the expense here.) DSS or other county partners' salaries are to be listed in this section.			
<b>Contractor/Consultant and description of service (List them individually)</b>	<b>Unit Rate</b>	<b># of Units (Consultant)</b>	<b>Program Total</b>
<b>TOTAL Contractors/Consultants:</b>			
<b>8. Total Budget: (numbers 1-7)</b>			
<b>10. Local Funds: Describe Below</b>			
<b>TOTAL Local Funds:</b>			

# Balancing Incentive Program (BIP) Caregiver Support Program 2015-2017

## CONTRACTOR SUMMARY BUDGET

Contractor: \_\_\_\_\_ **Allocation Amount**

Program Period: April 1, 2015 - June 30, 2017

	<b>Budget Category</b>	<b>Budget Amount</b>
1	Personnel	
2	Fringe Benefits	
3	Equipment	
4	Travel	
5	Maintenance and Operations	
6	Other Expenses	
7	Contracts and/or Consultants	
8	<b>Total Budget (Sum of Lines 1-7)</b>	

Note: Total budget amount on Budget Summary must equal total budget amount on last page.



## Balancing Incentive Program (BIP) Caregiver Support Program 2015-2017 Contractor Supporting Budget Schedule

Contractor: \_\_\_\_\_

**3. Equipment:** List all equipment items whether purchased or leased. Provide a detailed description for all equipment with a unit cost of \$1,000 or more. For equipment with a unit cost of less than \$1,000, list the items and the total for these items under Miscellaneous Equipment.

Item and Description	Quantity	Unit Purchase Price	Annual Rental Per Unit	Amount Chargeable to Program

<b>Miscellaneous Equipment- List Items</b>	
	Enter total cost for misc. items →
<b>TOTAL Equipment:</b>	

**4. Travel:** List travel costs. Outline reason for travel and indicate the number of staff traveling (e.g., staff to training, field interviews, advisory group meeting, etc.). Show the basis of computation (e.g., two people to 3-day training at \$X airfare, \$X lodging, \$X food).

Mileage: _____ miles @ _____ per mile		
Parking & Tolls		
Public Transportation:		
Rental Vehicles (specify destination):		
Other Travel Costs (Specify):		

Reasons for Travel:	
<b>TOTAL Travel</b>	

**5. Maintenance & Operations:** In the space provided, detail each expense.

Equipment Maintenance and Repair:	Program Expenses		
Postage:			
Printing & Photocopying:			
Rent:			
NY Connects:	Monthly Rent	% Charge to Prg	No. of months
Location:			
Owner:			
Supplies:			
Telephone:			
Utilities:			
<b>TOTAL M&amp;O:</b>			

# Balancing Incentive Program (BIP) Caregiver Support Program 2015-2017 Contractor Supporting Budget Schedule

Contractor: \_\_\_\_\_

<b>6. Other Expenses: List specific item and cost.</b>			
Promotional materials in the form of informational brochures and the like and "Giveaways" are not allowable expenses under this funding.			
Itemize all Information Technology (IT) costs and provide a justification. This includes such things as the number of licensing user fees, for whom and associated cost, licensing agreement amount, maintenance cost, reporting upgrading fees and/or, program website costs.			
			<b>Program Expenses</b>
<b>Public Education:</b>			
<b>Information Technology:</b>			
<b>Other (Specify):</b>			
<b>TOTAL Other Expenses:</b>			
<b>7. Subcontracts/Consultants:</b> List each subcontractor or consultant and amount below. A copy of each contract or consultant agreement must be submitted to NYSOFA before reimbursement will be made. Complete and submit a Contractor Budget for each contractor that will receive 25% or more of your grant amount. For Consultants, please list unit rate (e.g., \$25 per hour) and Number of Units in the columns provided. (Note: If you hire a translator, language and/or sign interpreter, include the expense here.) DSS or other county partners' salaries are to be listed in this section.			
<b>Subcontractor/Consultant and description of service (List them individually)</b>	<b>Unit Rate</b>	<b># of Units (Consultant)</b>	<b>Program Total</b>
<b>TOTAL Contractors/Consultants:</b>			
<b>8. Total Budget: (numbers 1-7)</b>			

## **Balancing Incentive Program (BIP) Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised)**

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### Background and Instructions

The BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised) is the designated instrument to be used to:

- Collect basic information about the Caregiver who will receive services and supports from this Program.
- Describe the Caregiver's needs.
- Document the Care Receiver's Medicaid status.
- Collect basic information about the Care Receiver that will help determine the appropriate services to support the Caregiver.
- For the Caregiver to be eligible for Respite or Supplemental Services, the Care Receiver must:
  - have a cognitive impairment or other mental impairment; or
  - be unable to perform at least two (2) Activities of Daily Living (ADLs); or
  - be unable to perform at least two (2) Instrumental Activities of Daily Living (IADLs) for the Caregiver to be eligible for respite or supplemental services.

Note: This BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised) will **not** replace the Minimum Data Set compliant form (e.g., the COMPASS) for the services that require that level of information per 97-PI-01 (Housekeeper/Chore, Homemaker/Personal Care, Case Management, Home Health Aide Services, Home Delivered Meals, and Social Adult Day Care services).

- A completed and signed copy of the BIP Caregiver Support Program Caregiver/Care Receiver Required Information Form (revised) must be maintained by the AAA in the Care Receiver's client file for monitoring and audit purposes.

County/AAA: \_\_\_\_\_

Case Manager/Caregiver Coordinator: \_\_\_\_\_

Referral Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred by: \_\_\_\_\_

**CAREGIVER Information Section (all information to be provided by the primary Caregiver)**

First and Last Name:		
Street Address:		
City/Town:		ZIP Code:
E-Mail:		Phone (home):
Phone: (work)	Phone (Cell)	
Date of Birth:    /    /		
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic Latino
What is the caregiver's race (check one)?		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> White not Hispanic	<input type="checkbox"/> White Hispanic
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other Race
<input type="checkbox"/> Asian	<input type="checkbox"/> Two or More Races	
In my relationship with the care receiver I am the:		
<input type="checkbox"/> Husband	<input type="checkbox"/> Son/Son-in-law	
<input type="checkbox"/> Wife	<input type="checkbox"/> Other Relative (specify): _____	
<input type="checkbox"/> Daughter/Daughter-in-law	<input type="checkbox"/> Non-Relative (specify): _____	

**CAREGIVER Information Section, *continued***

What are the Caregiver's unmet needs that may be provided by this program (describe):

**Required Attestation**

I attest that I am the primary Caregiver for the Care Receiver whose information is provided on this Form, and that the information is accurate to the best of my knowledge.

Primary Caregiver Signature:

Date:

**CARE RECEIVER Information Section**

**(All information in this section may be provided by the Caregiver or Care Receiver or may be transferred from other forms (e.g., the COMPASS, or UAS-NY), if available and completed within the previous 6 months prior to completing this form).**

First and Last Name:			
Street Address:			
City/Town:		ZIP Code:	
E-Mail:		Phone (home):	
Phone: (work)	Phone (Cell)	Live with the Caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth:    /    /		Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Lives Alone: <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: (Check one) <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single (Never Married) <input type="checkbox"/> Domestic Partner or Significant Other		
Disabled: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Visually Impaired	
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Ethnicity:	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic Latino	
What is the Care Receiver's race (check one)?			
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> White not Hispanic	<input type="checkbox"/> White Hispanic	
<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other Race	
<input type="checkbox"/> Asian	<input type="checkbox"/> Two or more Races		
Limited English Proficiency: <input type="checkbox"/> Yes <input type="checkbox"/> No			

**CARE RECEIVER Information, *continued***

**Care Receiver must be Medicaid eligible**

Medicaid ID Number: \_\_\_\_\_

Medicaid Eligibility Verification Information obtained from:

LDSS Staff

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Care Receiver is Participating/Enrolled in (check one):

- Managed Long Term Care
- Managed Care
- Personal Care
- Consumer Directed Personal Assistance Program
- Home Health
- Adult Day Health Care
- Community-based Hospice
- Long term Home Health Care Program Waiver
- Traumatic Brain Injury (TBI) Waiver
- Nursing Home Transition and Diversion (NHTD) Waiver
- Assisted Living Program
- Private Duty Nursing
- Health Homes
- People First Waiver
- Other (specify): \_\_\_\_\_

Information obtained from (specify source/name): \_\_\_\_\_

**CARE RECEIVER Information, continued**

Completion of this page is **mandatory** if Respite and/or Supplemental Services are planned.

For the Caregiver to be eligible for Respite and Supplemental Services, the Care Receiver must meet at least one of the following requirements:

- (1) Care Receiver has a cognitive impairment or other mental impairment; or
- (2) Care Receiver is unable to perform at least two (2) Activities of Daily Living (ADLs) that require human assistance to accomplish; or
- (3) Care Receiver is unable to perform at least two (2) Instrumental Activities of Daily Living (IADLs) that require human assistance to accomplish.

**Cognitive or other mental impairment(s)**

List/describe any cognitive or other mental impairment(s) of the Care Receiver requiring substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual:

Source of information (check one): Caregiver: \_\_\_ Medical assessment: \_\_\_ Other (specify): \_\_\_\_\_

**Activities of Daily Living (ADLs)**

Activities of Daily Living Care receiver needs assistance with:	Independent (Totally able)	Needs intermittent supervision and/or minimal assistance	Needs continual help with all or most of this task	Person does not participate; another person performs all aspects of this task
Personal Hygiene				
Mobility				
Transfer				
Toileting				
Eating				
Bathing				
Dressing				

Source of information (check one): Caregiver: \_\_\_ Medical assessment: \_\_\_ Other (specify): \_\_\_\_\_

**Instrumental Activities of Daily Living (IADLs)**

Instrumental Activities of Daily Living care receiver needs assistance with:	Independent (Totally able)	Needs intermittent supervision and/or minimal assistance	Needs continual help with all or most of this task	Person does not participate; another person performs all aspects of this task
Housekeeping				
Shopping				
Preparing Meals				
Managing Money				
Laundry				
Using Transportation				
Telephoning				
Taking Medication				

Source of information (check one): Caregiver: \_\_\_ Medical assessment: \_\_\_ Other (specify): \_\_\_\_\_

**Can the Care Receiver be left alone?**  Yes  No If No, describe: \_\_\_\_\_