

**BLUEGRASS AREA AGENCY ON AGING
FAMILY CAREGIVER SUPPORT PROGRAM**

INTAKE / SERVICE REQUEST & APPROVAL FORM

Intake Portion:

Date: ___/___/___

Family Caregiver: Name _____
 Address _____
 City, State & Zip _____
 Phone # (Home) _____ (Work) _____ County: _____

Date of Birth: ___/___/___ Social Security Number: _____-_____-_____ This information will only be used for tracking purposes, and will not be shared with others.

We would like to make your address available (on an address label – not a database) to local non-profits when they have information on your loved one's condition, or an upcoming event that we think would be helpful to you. Check this box only if you object to this.

Person Being Cared For: Name _____
 Street _____
 City, State & Zip _____
 Phone # _____ County: _____ Date of Birth: ___/___/___
 (Check One)

If an Elder, the Person Being Cared For's Primary Diagnoses (Check all that apply):

Alzheimer's/Dementia	Heart Problems	Parkinson's
Arthritis	HIV/AIDS	Podiatry
Audio Problems	Incontinence	Stroke
Cancer	Non-Ambulatory	Vision Problems
Diabetes	Pain	Other: _____

Service Request / Approval Portion:

- Service Type Requested:** Respite ___ -Or- Supplemental ___ - (Specify) _____
- Service Provider (Please Choose One):** _____
For a list of Eligible Service Providers, contact David Bassoni or Cheryl Goodman at (859) 269-8021
- \$ Amount Requested:** _____
- Requested by:** _____ **Agency:** _____ **Date:** ___/___/___

For Administrative Use Only. Must have 2 "Approved" signatures before Approval is valid.

\$ Amount Approved: _____ **County:** _____ **Expires:** ___/___/___