

TEAM SUZY GRANT APPLICATION

PLEASE PRINT

Please attach additional pages for extended responses, if needed

SECTION A - Person Completing Application

If the Person Completing Application is the Primary Caregiver, Start with Section B.

Name: _____

Address: _____

Telephone: _____ Email: _____

1. How did you learn about Team Suzy Grants?

2. Are you the Primary Caregiver for the Person with Dementia? Yes No

If yes, Skip to Section B – Primary Caregiver

If no: What is your relationship to the Primary Caregiver and/or the Person with Dementia?

3. How long have you known the Primary Caregiver and/or the Person with Dementia?

Primary Caregiver ____ # months/years; Person with Dementia ____ # of months / years

4. Is the Primary Caregiver aware you are submitting this application? Yes No

If no, please explain: _____

SECTION B - Primary Caregiver

If the Applicant is NOT the Primary Caregiver – Please Contact Primary Caregiver to Complete.

Name: _____

Address: _____

Telephone: _____ Email: _____

Relationship to Person with Dementia: _____

1. How did you learn about Team Suzy Grants?

2. List agencies (Alzheimer’s Association, Area Agency on Aging, other) from which you’ve gotten information or support. Detail reason(s) for contact.

- a. _____
- b. _____
- c. _____

3. Have you attended a Support Group? Yes No

4. Are you currently attending a Support Group? Yes No

5. How have you learned about Dementia and/or Caregiving (seminars, books, or videos)?
Please provide specifics:

6. Do you work outside the home? Yes No
If so, please describe position: _____ and hours worked:

Full-time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weekly Hours _____
Part-time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Weekly Hours _____
Weekends	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Hours _____
Overtime	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Hours/week: _____

7. Do you have a spouse or partner? Yes No
If yes, does the spouse or partner work outside the home? Yes No

If so, please describe position: _____ and hours worked:

Full-time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hours/Week _____
Part-time	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hours/Week _____
Weekends	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Hours _____
Overtime	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Hours/week _____

SECTION C - Person with Dementia

Name: _____ DOB: _____

Address: _____

Telephone: _____ Email: _____

***** Please provide a copy of the Person with Dementia's driver's license or picture ID *****

- 1. Is the Person with Dementia a U.S. citizen? Yes No
- 2. Does the Person with Dementia live in an adult care facility? Yes No
- 3. Does the Person with Dementia live with the Primary Caregiver? Yes No

If no, where does the Person with Dementia live? _____

- 4. Please describe the home where the Person with Dementia lives (# floors; bedrooms; bathrooms).

- 5. Does the Person with Dementia have a bedroom of their own? Yes No

If No, where do they sleep: _____

- 6. List everyone in the Person with Dementia's household, their age and relationship to the **Person with Dementia**.

- a. _____ Age _____ Relationship _____
- b. _____ Age _____ Relationship _____
- c. _____ Age _____ Relationship _____
- d. _____ Age _____ Relationship _____
- e. _____ Age _____ Relationship _____

- 7. Please list the Person with Dementia's immediate and extended family.

Indicate how each person helps with the Person with Dementia's care/well-being, including tasks performed for the Person with Dementia as well as for the household, in general, where the Person with Dementia lives.

- a. _____ Relationship _____ Helps _____
- b. _____ Relationship _____ Helps _____
- c. _____ Relationship _____ Helps _____
- d. _____ Relationship _____ Helps _____

SECTION D – Health of Person with Dementia

1. At what stage in the disease is the Person with Dementia: Early; Mid; Late? _____
2. Has the Person with Dementia received a diagnosis from a doctor? Yes No
If yes, what is the diagnosis? _____

Please provide a letter (dated w/in 6 months) and on Doctor’s Letterhead, confirming the diagnosis.

3. List the Person with Dementia’s other health conditions:
 - a. _____
 - b. _____
 - c. _____
 - d. _____
 - e. _____

4. Does the Person with Dementia?
 - a. Speak Yes No Sometimes
 - b. Follow simple commands Yes No Sometimes
 - c. Follow complex commands Yes No Sometimes

5. Can the Person with Dementia perform the following Activities of Daily Living (ADLs)?
 - a. Eating Always With Cueing Never
 - b. Dressing Always With Cueing Never
 - c. Getting in/out bed or chair Always With Cueing Never
 - d. Bathing Always With Cueing Never
 - e. Toileting Always With Cueing Never

6. Does the Person with Dementia?
 - a. Walk Yes No Sometimes
 - b. Fall Yes No Sometimes
 - c. Wander Yes No Sometimes

7. What assistive devices for mobility (cane, walker, wheelchair, gait belt, grab bars, raised toilet seat, commode, other) have been prescribed or recommended? If any, does the Person with Dementia use such devices without assistance? Please explain:

8. What safety devices (bed or door alarms, locks, cameras, other) are being used?

9. Has the Person with Dementia had Physical, Occupational, or Speech therapy? Yes No
If yes, please explain: _____

Has such therapy been productive? Yes No Somewhat

10. Please describe how the Person with Dementia's typical day is structured:

Morning: _____ Afternoon:
n: _____ Evening:

11. Does the Person with Dementia participate in these daily activities?

- | | | | |
|-----------------|------------------------------|-----------------------------|------------------------------------|
| a. Meals | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| b. Exercise | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| c. Activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| d. Appointments | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |

12. Does the Person with Dementia attend any Adult Day Programs? Yes No
If yes, please describe the program; the days and number of hours attended each day:

13. Has the Person with Dementia previously attended an Adult Day Program? Yes No
If yes, please explain why the Person with Dementia no longer attends the program:

SECTION E – Caregiving

1. List any outside services or individuals (agencies, family, friends, acquaintances, visiting nurse) providing care for the Person with Dementia? Please list and describe tasks performed for the Person with Dementia, as well as tasks performed for the household, in general.

- a. Name _____ Relationship or Agency _____
Tasks: _____
- b. Name _____ Relationship or Agency _____
Tasks: _____
- c. Name _____ Relationship or Agency _____
Tasks: _____
- d. Name _____ Relationship or Agency _____
Tasks: _____

SECTION F - Purpose of Grant Request

Please Note: Team Suzy is unable to provide grants for home improvements or remodeling.

1. What services and/or products are being requested? For instance: respite care; day care; mobility / safety improvements; tracking watch; camera; alarms, etc. Please include any information that may be pertinent to your request(s), including, if known, products or service providers and cost.

- a. _____
- b. _____
- c. _____
- d. _____

SECTION G – Primary Caregiver References

Name: _____ Relationship: _____
Telephone Number: _____ Email: _____

Name: _____ Relationship: _____
Telephone Number: _____ Email: _____

Name: _____ Relationship: _____
Telephone Number: _____ Email: _____

Please ensure each reference is aware Team Suzy may contact them.

SECTION H – Certification

I certify all information is complete and accurate to the best of my knowledge. Yes No

I understand if I knowingly provide untruthful or fraudulent information, my application will be denied. Yes No

I further understand if Team Suzy approves a grant based on information I provide, and it is subsequently determined such information is untruthful or fraudulent, I must repay, in full, any money, products, or services received. Yes No

Signature: _____ Date _____

Print Name: _____

Please submit completed application:

By Email: Hello@teamsuzy.com
By Mail: Team Suzy Attn: Grant Review Team #P.O. Box 725009 Berkley, MI 48072

Please retain a copy of your application for your records.

A representative from Team Suzy will contact you after reviewing your application.

THANK YOU FOR CHOOSING TEAM SUZY