Team Suzy, INC

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	☐ Yes	☐ No	Weekly Hours_____
Part-time	☐ Yes	☐ No	Weekly Hours _____
Weekends	☐ Yes	☐ No	# Hours _____
Overtime	☐ Yes	☐ 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	☐ Yes	☐ No	Hours/Week _____
Part-time	☐ Yes	☐ No	Hours/Week _____
Weekends	☐ Yes	☐ No	# Hours _____
Overtime	☐ Yes	☐ 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 devises 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:_____Evening:_____

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

a.	Meals	☐ Yes	☐ No	☐ Sometimes
b.	Exercise	☐ Yes	☐ No	☐ Sometimes
c.	Activities	☐ Yes	☐ No	☐ Sometimes
d.	Appointments	☐ Yes	☐ No	☐ 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