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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-21343E (04/2020) |  | **STATE OF WISCONSIN** |
| **ALZHEIMER’S FAMILY CAREGIVER SUPPORT PROGRAM (AFCSP)general information** |
| The information on this form will be used to coordinate services for the Wisconsin Alzheimer’s Family Caregiver Support Program. It will not be used for any other purpose or be shared with any other agency without the written consent of the applicant. The information will not be sold to third parties. AFCSP participants have the right to review this form and request changes to their personal information at any time to assure accuracy. **Instructions**: To avoid repetition for AFCSP applicants with memory loss and their family members, program coordinators should complete this form using information collected on intake/referral forms supplied by ADRC staff whenever possible. [ ]  Verified 1. Verify that at least one member of the household, or the person who lives in a CBRF, adult home, or other qualifying residential facility, has received a final, tentative or preliminary written diagnosis of Alzheimer’s disease or related irreversible dementia from a physician. (attach documentation) 2. Review this information annually and make changes as needed. |
| Name – Applicant or Client (Last) | (MI) | (First) | Date of Application |
|       |    |       |       |
| Date of Birth      | Sex[ ]  Male [ ]  Female | Does applicant have a primary caregiver?[ ]  Yes [ ]  No |
| Address      | City      | State   | Zip Code      |
| Name – Spouse or Primary Caregiver      | Date of Birth      | Telephone Number      |
| Address (If different from applicant)      | City      | State   | Zip Code      |
| Name – Person responsible for turning in monthly receipts      | Telephone Number      |
| **ADDITIONAL VOLUNTARY INFORMATION****Has a legal guardian been appointed?** **[ ]** Yes—Date Appointed       [ ]  No |
| Name – Legal Guardian      | Telephone Number      |
| Address      | City      | State   | Zip Code      |
| **Has financial power of attorney been appointed? [ ]** Yes—Date Activated       [ ]  No |
| Name – Power of Attorney      | Telephone Number      |
| Address      | City      | State   | Zip Code      |
| **Has health care power of attorney been appointed? [ ]** Yes—Date Activated       [ ]  No |
| Name – Health Care       | Telephone Number      |
| Address      | City      | State   | Zip Code      |